GROWING

IN THE OLDER YEARS

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EDITED BY
WILMA DONAHUE and CLARK TIBBITTS

WITH A FOREWORD BY
EVERETT J. SOOP

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FOREWORD

Three conferences on problems of our aging population have now been held at the University of Michigan. Preceding and between the summer conferences, the Institute for Human Adjustment and the University Extension Service have expanded the program by offering classes, conducting research, and developing radio programs and recordings for community use. The scarcity of published material and the growing need for it, as evidenced in the increasing interest in gerontology, resulted in the decision by the original planning group that the basic information developed or presented should be preserved and made available in published form.

The first volume, *Living Through the Older Years,* was a general survey of the total problem. The second, *Planning the Older Years,* was organized around three of the need areas identified by older people themselves: living arrangements, recreational activities, and employment. This third volume, *Growing in the Older Years,* focuses attention on medical health, mental hygiene, and education. In accordance with the pattern of the preceding publications, many of the papers presented at the 1950 Institute on Aging are included in this volume.

Throughout the growth of the program, the Institute for Human Adjustment and the University Extension Service have had the continued encouragement of their executive committees and the chief executive and administrative officers of the University. Their active support has made the publication of these three volumes possible.

For the materials presented in the three volumes, indebtedness is acknowledged to the following members of the University of Michigan faculty and staff: Dorothy H. Coons, Wilma T. Donahue, Moses M. Frohlich, Roger W. Heyns, Woodrow W. Hunter, Frank E. Robbins, Leroy Waterman, and Carl V. Weller; and to these leaders from all sections of the United States who also contributed: Harry Becker, Ernest W. Burgess, Ewan Clague, John M. Convery, Henry S. Curtis, Michael M. Dacso, Robert H. Felix, Robert J. Havighurst, Charles V. Kidd, William B. Kountz, Helen Graves Laue, George Lawton, Newton D. Leyda, Joseph W. Mountin, Harry A. Overstreet, Patricia M. Rabinovitz, Ollie A. Randall, Nathan W. Shock, Edward J. Stieglitz, Clark Tibbitts, Thomas A. Van Sant, Jack Weinberg, and Coleman Woodbury.

To them, and to the staff of the University of Michigan Press, appreciation is herewith expressed.

EVERETT J. SOOP
Director of the University Extension Service

PREFACE

This volume is the third in a trilogy dealing with the older years. Its purpose, like that of its companion publications, *Living Through the Older Years* and *Planning the Older Years*, is to give intensive consideration to the problems which older people have identified for us as the most crucial in their adjustment to aging. It is our hope that these books will bring guidance, inspiration, and knowledge to people who wish to explore the potentialities of their later years, and that they will provide direction for the thinking and planning of those who are concerned with the welfare of older people.

It would be impossible, in this final volume, to overlook the part so many others have had in the initiation of our interest and the realization of our goals. President Alexander Ruthven, Dean Ralph Sawyer, the late Dr. Charles Fisher, and Mr. Everett Soop have all contributed generously of their time, knowledge, and energy and have shared their resources in making possible the annual University of Michigan conference on aging and the publication of its proceedings. Finally, without the sustained effort of Mr. Roger Berry, these three volumes would not have reached completion.

WILMA DONAHUE and CLARK TIBBITTS

Ann Arbor and Washington, D C.
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CONTENTS

NATIONAL ASPECTS OF AN AGING POPULATION

BY CLARK TIBBITTS

Clark Tibbitts, B.S., is assistant chief of the Division of Public Health Methods of the Public Health Service and chairman of the Committee on Aging and Geriatrics, Federal Security Agency, Washington, D.C. He was formerly director of the Institute for Human Adjustment at the University of Michigan, where he initiated research in Aging. He is chairman of the Committee on Education for an Aging Population which was formed by the Department of Adult Education of the National Education Association. He served as director of the First National Conference on Aging called by President Truman and held in Washington, D.C., in August, 1950, under the sponsorship of the Federal Security Agency. He is editor of Living Through the Older Years *and co-editor of* Planning the Older Years, *the two volumes which contain the proceedings of the 1948 and 1949 institutes on Living in the Later Years held at the University of Michigan, and the author of many other papers dealing with the problems of an aging population.*

TWO YEARS AGO, when the first University of Michigan conference on aging was held, no one could possibly have known the extent of the nation's interest in the problems of its older population. For some time, there has been an awakening interest in these problems here and there in the country. It was not until the last several weeks, however, when the first co-ordinated effort was made to determine what leaders in industry, labor, church organizations, professional groups, voluntary agencies, civic and community associations, and others think about the problems of the aging that either the intensity or scope of the interest began to be known. It is little short of overwhelming

In response to this manifest concern on the part of people in many different walks of life, the President of the United States, early in June, wrote to the Federal Security Administrator asking him to explore with all appropriate groups, both within and outside the federal government, the problems incident to our aging population and to report to him the findings and recommendations. As a first step in carrying out the President's request, Mr. Ewing called a National Conference on Aging which was held in Washington in August, 1950.

This National Conference did not, of course, represent the first activity on a national scale. The work of the Committee on Economic Security was done during the middle thirties and resulted in the passage of the Social Security Act, not entirely, but primarily directed toward provision of financial security for older people. There are two professional organizations of national scope: the Gerontological Society, Inc., and the American Geriatrics Society. The American Psychological Association has a division on maturity and old age. The Department of Adult Education of the National Education Association has a committee on education for aging. The United States Chamber of Commerce and the National Association of Manufacturers have both established committees and held conferences, or conducted studies, on one or more aspects of the aging problem. Labor organizations have become increasingly conscious of the changing situation. Recently, the final step was taken toward establishing a national committee on aging representative of numerous domiciliary, welfare, social work, and related interests. There are also organizations of older people which are now national or are becoming national in scope.

Most, if not all, of these developments on a *national* scale

have stemmed from state or local activities. Indeed, it is state and local effort which has demonstrated the need for additional work on a national scale.

Educational programs for older people have been developed by the University of Michigan to a greater extent than anywhere else in the country. The University may well be proud of the pioneering job it is doing, not only because of the benefits immediately observable within the state, but also for the many examples that Dr. Donahue and Mr. Soop could provide of other communities that are developing programs based on Michigan's experience. Without tracing this history, I can say that the success of the previous University of Michigan conferences has been an important influence both in reaching a decision to call a national conference and in establishing the pattern of that conference.

ROOTS OF THE PROBLEM OF AGING

First of all, in America, the problem of aging derives from population changes. The combined influences of a declining birth rate, the extension of life expectancy, and the virtual cessation of immigration have fundamentally changed the age distribution of the population.

A second factor is that of industrialization. The substitution of power and of machines for simple, hand-operated tools, both in the factory and on the farm, have greatly increased the productivity of the worker. The result is that there have been, at times, many more persons in the labor force than we have been able to provide with jobs. Since earlier age distribution focused attention on youth and organized society around youth, it is the older worker who suffers most during those periods.

The third factor is that of urbanization. As Professor

Burgess pointed out, urban environment appears to be much less suited than rural environment for satisfactory living during the older years.[1] I need not develop this thought further. I should like to say, however, that one should not accept too complacently the thought that older people always make easy or successful adjustments in rural areas. The first research in this field indicates that the problem is far more fundamental than that which is implied by merely rural versus urban residence.

Some people would add a fourth factor to the problem of aging, namely, the American value system, which demands opportunity for useful, creative, and satisfying life for all citizens of all ages. Under this system of values, society also imposes an obligation on the individual to continue to develop his potentialities not only during his first forty years, but throughout the period of senescence as well.

The fact is, however, that increasingly, among the large and growing population of older people, this opportunity is not available. Many of them want, but do not have, jobs that will enable them to be useful. Most of them have insufficient incomes. Health services are inadequate. Living arrangements are generally unsatisfactory, and this question, in turn, is tied up with the financial circumstances of older people, with their needs for independence and companionship, and with the conflicting desires of younger people to provide for their own children and simultaneously to discharge their responsibilities toward their parents.

The net effect of all these developments is the creation of an essentially new environment in which there is little tradition to serve as a guide for living through the older

1 Ernest W. Burgess, "The Growing Problem of Aging," *Living Through the Older Years* (Ann Arbor: Univ. Mich. Press, 1949), Chap I, pp 8 11.

years with their numerous crises—departure of children, loss of spouse and of friends, reduction of income, and impairment of vigor and health. In our communities, oriented as they are toward youth, opportunities for adequate expression of personality and interests are comparatively few.

These changes require adaptation, as I think all will agree. Individuals have to learn to adjust their behavior to the changes that come with age and must take the initiative in the process. Perhaps the first fifteen to twenty-five years of the individual were spent in learning to live an active and creative life. The changes of senescence and of the older person's situation are as profound as those which occur during youth. It is entirely logical, then, to think of preparation for aging.

Let me illustrate my meaning. Only yesterday a fine, resourceful woman of seventy-two said to me: "When one has given her life to serve others, first children and later other members of the family, and when they are gone and one is all alone—there is no longer any use to live, life has lost its meaning, there is no substitute." This is true, not because she and thousands like her no longer have resource, energy, health, and a drive to be useful, but true because she and others have grown old during an era in which there was little or no recognition that in this last half century the problem of older persons would become one of the most critical of the times. I could offer this woman but scant comfort, because I had to say that we have failed to educate people or to provide an opportunity for them to live the kind of lives which will continue to abound in rewarding experience.

Most people, fortunately, now recognize the community's responsibility to provide that education. Many people and communities are beginning to realize, also, that no matter

how much older people learn, they cannot make adaptations until appropriate health services, living arrangements, jobs, and opportunities for creative and social expression are available to them. Some communities and organizations are developing this concept now and are experimenting with the provision of services and facilities that will enable older people to grow in full maturity.

There is divided opinion as to where local and state responsibility end and where responsibility on a national scale begins. The dividing line will undoubtedly vary with the particular problem at hand. Let me say at this point that when I say "national" I do not mean federal. Rather, I refer to responsibility on the part of all types of agencies and organizations, governmental and nongovernmental, operating on a nation-wide basis.

In my own view, the problems of aging have grown out of circumstances that developed on a country-wide scale or that respresented country-wide attitudes and policy. I think it will become clear, as a good many have recognized, that some of the problems facing individuals, families, and local communities can be successfully attacked only within a framework of policies and programs developed on a nation-wide basis and, hence, by national organizations.

LIVING ARRANGEMENTS

A consideration of the problem of living arrangements is a good place to start a discussion of those phases of the question which appear to me to be of national concern.

Prior to industrialization, most families were institutional units in the sense that the income was earned in the home. The family provided its own protective, health, educational, recreational, and religious services. It met the needs of its members for affection and companionship.

Grandfather and grandmother were assets in the family; there was plenty for them to do and room for them in the house. Gradually, the living was earned out of the home, and most of the other functions were given over to such organizations as the church, the school, the health agencies, the police department, and the militia. The modern family has come to exist primarily to provide companionship for its immediate members. There is neither activity nor space in the urban family unit for the older generation.

One of the first crises that marks the onset of aging, then, is the breakup of the family, when the children leave to set up their own homes, often scattering over the country. The aging parents may be left with an establishment too large to maintain as their physical capacities decline and too expensive to keep up if employment fails. They are also faced with the need for close friends to replace children and with the need for care as illness or infirmity set in.

Some older people can satisfy their needs within the range of existing facilities, but for others housing that meets even a majority of their needs either does not exist or is beyond their financial reach. It is encouraging to know that in a few communities experimental projects are under way. Most of them, however, are of a philanthropic character, and philanthropy cannot be expected to meet the total need For understandable reasons, private enterprise has not become concerned with housing for older persons. Nor has subsidized housing become a matter of local community initiative.

Thus, it seems to me that living arrangements for older people become a matter of national concern. National agencies concerned with the general well-being must recognize housing needs, including the financial considerations They must seek solutions through research, advise states

and local communities, and render such other assistance as may be necessary.

Another phase of the problem with national aspects is that of *institutional housing*. Only about 4 per cent of older people live in institutions. This is, however, nearly a half million persons. This proportion may well increase as more people live into the period of infirmity and the age of high incidence of chronic illness.

Newer knowledge of the needs of older people places most congregate living in a poor light. Institutionalization generally means uprooting the individual from his family and community and placing him in an isolated group where there is little to do but vegetate until death arrives. The reason for the well-known antagonism of older people toward entering homes for the aged becomes clear as one gains a better understanding of the desires of older people to continue as useful participating citizens. Confinement or removal to a home represents the opposite. It is the last phase of withdrawal from independence and community life.

Public homes for the aged are generally less satisfactory than private ones As Dr. Henry Curtis has commented on the basis of his recent survey of infirmaries: "For the impoverished ones (older people) we have provided poor houses, which are a calamity to the aging poor."[2]

Determination of layout, program, and other characteristics of institutional housing may well be said to be a local matter. It has been learned in this country, however, that the amount of information and the level of conscience varies among groups and communities, and that it is desir-

[2] See Henry S. Curtis, "Almshouses, Poorhouses, or Infirmaries," *Planning the Older Years*, ed. by Wilma Donahue and Clark Tibbitts (Ann Arbor, Univ Mich. Press, 1950), pp 79-96.

able for state and national professional organizations and governmental agencies to disseminate information and to set standards for institutions and services.

HEALTH

For reasons that have long been obvious, the health of the American people is recognized as a national responsibility. Our great systems of disease control are carried on by many voluntary and public agencies. Through the combined efforts of these agencies—national, state, and local—we are living twenty years longer than did our grandparents.

As everyone knows, aging itself gives rise to many health problems. Of the deaths now, 80 per cent are from chronic diseases—heart disease, cerebral hemorrhage, cancer, nephritis, and others. These are not diseases of old age in the complete sense, because they attack people of all ages, but the heaviest concentrations are among people who have passed middle life.

In the matter of research national interest has been recognized, and much progress is being made in the detection and control of cancer, in the treatment of certain heart conditions, and now in arthritis and rheumatism, tuberculosis, and diabetes. National concern is manifested in the extent to which Congress supports the research and grants programs of the National Institutes of Health of the Public Health Service, and in the extent to which everyone supports the annual campaigns of the large voluntary health funds.

Save for a few outstanding advances, however, we are still far behind in the provision of health services. Recently, a group of health specialists from private agencies defined three objectives of health programs for older

people: (1) promotion of positive health, (2) prevention of premature disability, and (3) provision of therapeutic, rehabilitative, and palliative treatment and care for the sick and the disabled.

These objectives contemplate finding ways to provide health education and counseling for older people, periodic checkups and early detection of disease, hospitals and nursing homes with adequate care that older people can afford, and rehabilitation centers. All of these are on the horizon.

National interest dictates that there shall be equal facilities among the states, regardless of inequalities in state wealth. The Hospital Construction Act of 1946 makes it possible for state and local communities to set up hospitals and health centers, provided they take the initiative and pay part of the cost. The ultimate objective is to create within each state a network of health center and hospital facilities generally associated with medical schools. The postgraduate training program, whereby the University of Michigan Medical School carries its refresher courses into all areas of the state, is an outstanding example of this type of development.

Facilities for the care and rehabilitation of the chronically ill are a special problem. Thousands of senile people are unnecessarily occupying space in mental and general hospitals, because there is no other provision for their care. Institutions with less complex facilities and home-care plans are needed. A few communities are experimenting with methods of taking the hospital to the home, with significant reductions in cost to the individual and to the community. Some are combining activity and rehabilitation programs with hospital services for the chronically ill.

I need not go into this matter further, because it is dis-

cussed elsewhere.[3] It is sufficient to say that the health of older people is a matter of national concern, that national agencies, both voluntary and public, will doubtless continue to support research, to encourage the development of services and facilities, and to study, evaluate, and disseminate information about new and promising techniques and programs.

OPPORTUNITIES FOR PARTICIPATION

Continuing participation of older people to the fullest extent possible in the round of life's activities is the underlying objective of all the programs being discussed at this conference. Maturity is commonly spoken of as the stage of life when the peak of learning is reached, when one is able to make his own decisions, to support himself financially, and to maintain emotional balance during periods of crisis. After a time on that level, the individual is supposed to go into a period of decline. I should like to suggest that much of this thinking has been erroneous, that whatever may happen to one physically, personality continues to develop as long as one lives, learns, and remains active. Accumulated experience, maturity of judgment, and patience are perquisites of age. In this connection, let me quote a proverb from a culture so old that it has learned to respect old age:

> Wisdom is the light that shines in an old man's eyes
> As he watches the little child go tripping down the road
> After having asked the way. —*From the Chinese.*

As I have said earlier, one tenet of our society holds that every citizen should have an opportunity to lead a useful and creative life. This is [illegible]
objective. But the [illegible]

[3] See Chap II

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facilities. The problem, as I see it, is largely one of adapting existing facilities, encouraging the participation of older people, and developing new programs to meet their specific needs. This constitutes a challenge to virtually every type of community agency — schools, libraries, churches, community centers, Grange halls, clubs, fraternal organizations, luncheon groups, patriotic organizations, parks and playgrounds, health and welfare agencies, labor organizations, co-operative societies, the Chamber of Commerce, and art, musical, and literary groups.

The job is primarily a local one, because, in this country, we have wisely determined that educational and participation programs shall be developed on local initiative to meet local needs. The job, however, will not do itself. It will require specific attention and co-ordinated effort. Some agencies may have to resign long-time prerogatives or break with tradition in other ways. I recall one YMCA director who threw up his hands at the suggestion that he use his plant, empty during the daytime, for programs for older people.

Imagination will be needed. Recently, I asked a playground director whether she had developed anything for older people. Her reply was, "No, they are happy sitting on the benches watching the children play." I wish she would install a shuffle-board or croquet court and see the benches emptied

One problem, of course, is financial support. In most communities, the voluntary and public funds available are being spent primarily on services for children and youth. Ways will have to be found to break in with programs for older people. I strongly suspect that the older people themselves would find ways of doing it, if they were permitted to share the responsibility.

shall not have total national security and well-being until this opportunity has in fact been provided for all citizens. I believe that this well-being will not be ours as long as a large part of our population lives in neglect, discard, withdrawal, and discontent. Thus, provision of opportunities for continued growth and participation of older people becomes a national aspect of aging.

Shelter, financial security, and reasonably good health are important components of personal well-being. But there is another: recognition. Complete personal well-being depends upon recognition of a person as one having a responsible role in the economic, social, or religious life of his community. It is this component that has been most neglected.

We have tended to set older people aside instead of exploiting their skills and their accumulated wisdom. We have failed to recognize the persistence of their capacities to manage their own affairs, to learn, and to generate new ideas. I want to remind you that the original initiative behind the University of Michigan programs for older people came directly from three people who have or had lived a long time — President Alexander G. Ruthven, Dr. Henry Curtis, and the late Dr. Charles A. Fisher.

To repair the situation that has resulted from neglect, we must now reassess our attitudes toward older people. It will not be an easy task, since most institutional and community programs and their physical facilities have been built for youth. As an illustration, I recall that when we were looking for a classroom for the first course on Living in the Later Years, there was in the University of Michigan not one room on ground level with satisfactory lighting, good acoustics, and comfortable seats.

We cannot await the construction of new specialized

substantial source of support, but only for a relatively small proportion of older people. *The Midyear Economic Report to the President,*[5] records that 58 per cent of American families have less than $500 in savings even during the present period of prosperity. Further, the proportion of families with any savings at all is lower than it was two or three years ago.[6]

Thrift and self-reliance are prized elements in our system of values, but they are not equal to the task of guaranteeing sufficient income for the remainder of lifetime of those who are unable to work or of those who retire during their sixties. The character and vicissitudes of life, over which the individual may well have no control, make it impossible for the majority to accumulate a sizable estate. Two Englishmen, John Stuart Mill and Winston Churchill, noted for their adherence to principles of individual initiative, recognized the need to provide assistance in some form. Mr. Churchill has pointed out that not even the fear of perishing miserably in the workhouse was sufficient to enable all people to provide for their old age.

In our country where thrift has always been encouraged and where poverty is feared, two-thirds of all people more than sixty-five years of age require some outside assistance. Contributions of relatives and friends are made both in money and kind. I mentioned earlier that fewer families are able to accommodate grandparents in the home, which is one means of providing support. It is equally true that a decreasing population of children is unable to support immediate families and an increasing proportion of parents. I believe that one cannot look to relatives for the support

[5] (Washington, D.C.: Govt. [illegible]

[6] *Report of the* [illegible]
(Washington, [illegible]

FINANCIAL SECURITY

I have left the questions of financial security and employment to the last in order to make certain that the other and equally important aspects received proper emphasis. Actually, of course, there is more national activity in the financial area than in any other.

The problem of financial security has many ramifications which are receiving a good deal of attention these days. Public policy, adopted many years ago, demands that all people shall have at least a minimum subsistence income. The questions are concerned with how much this shall be and how it shall be provided.

Recently, Walter Reuther estimated than an elderly couple needs an income of $174 a month to live at a standard of mininum decency and to satisfy their more important requisites.[4] This figure is within the range of amounts set up by other authorities.

If all older people were to be supported as dependents at this level, the amount of public funds required would run to many billions of dollars. Fortunately, it is not necessary to support all older people in this way, but we can get a vision of what the cost would be if other sources were denied.

Income of older people is derived from five sources: gainful employment, work-connected pensions and annuities, personal savings including insurance, assistance from relatives and friends, and public assistance. There are no adequate data to show the total current income of older people nor the amount of support derived from these various sources. It is possible, however, to make a few guiding generalizations about them.

Personal savings and life insurance benefits constitute a

[4] *The Evening Star*, Washington, D.C., March 15, 1950, p A-7.

after sixty-five years of age and to their survivors and dependents. It is based on the familiar insurance principle with contributory payments made during the working period. Benefits are paid in accordance with individual circumstances as to length of life, employment, number of dependents and survivors, and previous earnings.

Old age and survivors insurance has had several deficiencies: the payments have been too small—$25 a month on the average; too few people have been covered—only 15 per cent of those more than sixty-five years of age; and there have been serious restriction on those who have tried to supplement the annuity payments through part-time earnings Congress is at present completing its work on a bill to improve all of these deficiencies. I should like to point out that the vote on the current bill was 333 to 14 in the House of Representatives and 81 to 2 in the Senate—evidence, I am sure, that financial security is accepted as a national aspect of aging.

Private pension plans have grown rapidly during the past few years, due primarily to the inadequacies of the federal program. Private systems are in full accord with the American spirit of individual and free enterprise. There are many people who believe, however, that they do not meet the needs of the situation. No one has spoken more clearly and carefully on this subject than Professor William Haber, of the University of Michigan Department of Economics, in an article which appeared in *Survey* for April, 1950.[7]

To summarize Dr. Haber's article, private pension plans limit the freedom of the worker to change jobs, discourage the hiring of older workers, are often unsound financially, are unequal in coverage and in benefits, and seldom make

[7] William Haber, "After 65—What About an Income," *Survey*, April, 1950, pp 177-80

of older people without accepting a lower level of living for all.

In this country poor relief for the aged and for other dependents dates back to the seventeenth century. During the 1930's the need for financial assistance from organized charity and local public funds became too great, and the states, with the help of the federal government, were forced to rescue millions of people from extreme poverty and starvation. As an expression of public concern, we now have the public assistance features of the social security program.

Public assistance is designed to make up deficiencies when other means of support are lacking or are inadequate. It is a direct financial grant shared by federal and state treasuries. It is restricted mainly to those persons over sixty-five years of age and, hence, fails to recognize the situation of people who are not so old but who are unable, through illness or other circumstances, to support themselves. The latter continue to be the responsibility of local communities.

There are more than two and three-quarters million persons sixty-five years of age or more receiving federal-state public assistance today. This program was originally designed to be small, but has grown to large proportions because of inadequacies in the companion social security program.

Work-connected pensions or annuities are of two principal types: (1) those represented by the thirteen thousand private pension systems set up by individual employers or industries, and (2) the old-age and survivors insurance program, which is the other major program for older people in the Social Security Act. The old age and survivors insurance system provides annuity payments to retired workers

the men and 7 per cent of the women sixty-five years old or more are working. There is evidence that few who are able to work retire voluntarily. It has been estimated that in 1948 these older workers contributed more than eleven billion dollars to the national income. Certainly, two of the compelling reasons to make jobs for older people are that their productive capacity can be used to provide a large amount of goods and services for all, and that as workers they are self-supporting and not financial dependents.

I have not cited many figures. Let me introduce a few. Current retirement ages frequently run from sixty to sixty-five or sixty-nine years. At the age of sixty-five, the average person can expect to live another fourteen years. Fourteen years is the equivalent of one-third of the normal working span. Shall this period of time be lost to the individual and to the community? And, bear in mind that this fourteen years is only an average. Half of those retired will live longer—up to thirty or thirty-five years. Thirty, or even twenty years in retirement!

Employment for older people raises many questions and problems. First, I believe that there is a matter of changing attitudes. With a wealth of young people in the population the belief was developed that young people constituted the best workers, and older applicants for jobs have been in disfavor. The attitude still prevails despite growing knowledge of the value of judgment based on accumulated experience, in spite of the performance of older men and women now employed (dramatized during the war), and regardless of the known improvements in health and our knowledge of the persistence of mental capacities. Recent research has shown that older workers compare very favorably with younger workers. I shall not repeat the facts

provision for survivors or for permanent disability. As Dr. Haber pointed out, many firms, in the past, have been unable to meet their pension obligations. It is one of the factors which sometimes makes it cheaper to go out of business. Another factor is that it is usually impossible to build up sufficient funds to provide for workers who enter the plan at advanced ages. And, if it were possible, the funds tied up would probably not be available for expansion of employment and productivity.

The requirement that the worker remain with the plant or industry in which he is covered restricts his ability to change jobs in order to find work that he may prefer or that is in keeping with his changing physical capacities. Likewise unemployed workers past forty-five years of age find it difficult to obtain new jobs. Many employers do not want them because they are too old to accumulate full pension rights without great cost to the employer. Thus, at a time when we are greatly concerned about increasing employment opportunities for older workers, the program for their economic security is decreasing their employment opportunities. In all truth, I should state that there are people who disagree with this point of view regarding the effects of private work-pension systems. Since economic security is a concern of the entire community, it is appropriate that research, whether publicly or privately supported, should be encouraged on a national scale.

EMPLOYMENT

This brings me to the final phase of the topic, namely, the prospects for employment for those older people who are willing and able to work or who wish to be rehabilitated for work. Researches in various places have demonstrated that older people want to work. More than 40 per cent of

would be to stimulate more research on such questions.

Shifting from one job to another should be based on medical and psychological evaluation of the individual. This calls for the knowledge suggested above and for professional services not available in most business and industrial establishments or in government agencies. It demands that greater attention be given to the concept of functional as opposed to chronological aging. It would also have to be accomplished within the framework of labor contracts, and most of these, I take it, have not been drawn with reference to this problem.

Other adaptations would be to pay workers who have slowed down at correspondingly lower rates and to permit older persons to work on a part-time basis. These adaptations have promise and are actually in sight, their general acceptance, however, will require a good deal of study, experiment, and negotiation. I should like to mention that one large university is said to be planning to allow its faculty members to taper off their responsibilities as they lose the vigor of middle age.

A common prescription for older workers is that they should retire to an enterprise of their own, such as subsistence farming, poultry-raising, or establishment of a small business It is perfectly true that many people do find satisfaction in such activities I should like to point out that such activities require capital, that they frequently involve moving to a new locality, that there is nearly always financial risk, that the activity may not be in keeping with the status of the individual's health, that we have been moving away from the notion of walking-plow agriculture, and that there must be a small-business saturation point.

Individual employment is largely a local matter, and local communities should do everything in their power to

since they are recorded in the proceedings of earlier Michigan conferences.

The number of jobs that can be made available is another problem. One hundred years ago, three-fourths of the older men were employed and worked seventy hours a week. Invention of machines and the application of power have reduced the proportion of older men employed to about two-fifths of the total. The work week averages about forty hours. Man-hour productivity is still increasing at the rate of 2.5 per cent to 3 per cent each year. These are long-time trends. How are more jobs to be provided in the face of them? I hope that we shall recognize the importance to the older person of usefulness and of the dignity of self-maintenance; the importance to the whole population of increasing production; and the significance of the threat of millions of unemployed older workers. These are certainly national as well as local considerations.

Employment does not occur in the abstract and workers do change with age. People work at specific jobs that require specific skills and capacities. Productivity is higher and workers are happier when their individual traits are matched with the requirements of the jobs they are doing. These facts have been demonstrated many times, particularly by disabled workers who have been rehabilitated and selectively placed.

One way to attack the employment problem, then, is to increase the research and experimentation on such subjects as the nature of the aging process, the characteristics of older workers, their performance in comparison with that of workers at other ages, the kinds of jobs they *cannot* do well, and the kinds they can do better than younger people. It seems to me that one of the greatest contributions the newly created National Science Foundation could make

MENTAL HEALTH IN AN AGING POPULATION

BY ROBERT H. FELIX

Robert H. Felix, M.D., M.P.H., is the director of the National Institute of Mental Health. He was formerly chief of the Mental Hygiene Division of the United States Public Health Service, and during World War II was senior medical officer of the United States Coast Guard Academy. He has been actively associated with various committees of the American Psychiatric Association and is an active member of many psychiatric and other medical organizations Dr. Felix has published numerous articles and papers on the various aspects of mental health.

THE SIMPLE fact that more than one-half of the population of the United States lives past the age of sixty-five presents an important problem of concern for mental health. It is not merely numbers, and increasing numbers at that, which force the problems of the aged upon the attention, but a changing society has intensified many problems that the aging in any era have had and has also brought new difficulties

THE SOCIAL AND ECONOMIC BACKGROUND

As more American families moved from the farm to the city, grandparents lost important functions and status. On the family farm the skills and the time of older members could always be well employed in numerous productive tasks In urban life father goes out to work, mother cares for the children, and grandmother, if she lives with the

stimulate change of attitudes toward older workers and to help find jobs. For obvious reasons, employment policies and practices are generally developed over a wider area, however, and it is a problem that is clearly national in scope.

CONCLUSION

I have tried to adhere to my topic—"National Aspects of an Aging Population." Here and there I have discussed local responsibilties. I have done this to emphasize my point that the problems of an aging population will be met only if the local aspects, state and regional aspects, and national aspects are recognized. We need to continue and to extend our work on a teamwork basis, including all types of interests and agencies at all levels.

As one person stated to me the other day, we have ten years of concentrated effort ahead of us to come abreast of the situation that is here now. And, following that, we shall have to continue our efforts, for the aging of the American population is a continuing process.

This does not mean, of course, a growing paternalistic welfare-state attitude of dependency toward older people, nor anything like that. What we really wish to bring about is a society of opportunity in which all people can live as functional, self-subsistent, satisfied members.

CHANGES WITH AGING

For somewhat deeper understanding of mental health in the aging population, let us examine some of the processes of aging — physical, mental, social, economic. It may be helpful to visualize a chart on which to trace some of the changes that occur during this aging process.

Growth is at its all-time high in the prenatal period and drops steadily thereafter. Thus, in a sense, aging begins in the cradle. The curve of reaction rises up to the mid-twenties and early thirties and then falls during the rest of the life span. Tests of mental ability usually show a peak at about twenty years and after that a gradual drop. Learning ability seems to follow a similar curve, but none of these facts provides a clear demarcation of old age. Instead, they illustrate the thesis that there is no specific point at which one is old.

Reproductive ability starts in the teens and continues through the forties or fifties in women and somewhat longer in men. A related function, caring for children, may last longer, but, since most children are born when the parents are in their twenties and thirties, this responsibility has usually ended by the time parents reach their mid-fifties and the children have married or at least are self-supporting and independent.

Economic aging varies even more. For some, loss of economic self-sufficiency starts abruptly at the retirement age of sixty-five. Others are faced with loss of employment and increased difficulty in finding jobs many years earlier. This is particularly true in a period of depression, when competition is intensified and gray hairs become an occupational liability at forty-five. Some people find themselves in occupations and with abilities that enable them to work productively into their seventh and even eighth decades. For the housewife the loss of economic function is usually

family, only makes the three-room apartment more crowded. Generally speaking, we have changed from the three-generation family to the two-generation family. A man becomes family head, not when his father dies, but at his marriage. Grandparents are often expected to live alone, whether they like it or not.

Economic conditions, too, have changed. In 1870, of the men over sixty-five, 80 per cent were employed; today the proportion is less than 50 per cent. The population shift from rural to urban life is probably one of the most important reasons for this change. Industrial employment places a premium upon speed and adaptability rather than upon skill and experience. Another important factor is the customary or legal provisions for retirement at sixty-five, or even earlier.

Thus, millions of older people must face a loss of social and economic usefulness, which in many cases is disproportionate to the actual decline in mental and physical capability. Looking toward the future, one may expect this problem to be intensified rather than reduced, unless current trends are modified.

In dealing with problems of older people we have generally taken the sixty-fifth birthday to mark the beginning of the period of old age. This is an arbitrary approach. Some people are old at fifty, others are still young at seventy-five. Changes in the arteries, visual changes, and deterioration of the nervous tissues progress at different rates in different individuals. Likewise, the emotional crises which can be potent factors in the aging process strike different people at different ages, and sometimes not at all. Thus, in studying the aged, one is dealing with a vast and diverse group whose members have widely varying needs.

acute or chronic illness. In general, physicians note that these situations are crises principally to people who have had difficulty in meeting similar critical situations in earlier life. In other words, mental health in old age depends a great deal upon mental health throughout life. Preparation for the process of aging starts in youth.

MENTAL ILLNESS IN THE AGED

The process of aging can bring not merely emotional crises but sometimes severe mental and emotional disorders. A fairly large proportion of the elderly are subject to mental deterioration and mental illness increasing as age increases. Very little is known about this group except for those of its members who have been admitted to psychiatric hospitals. In 1948 there were 25,146 admissions and the number has increased steadily during the entire period for which statistics have been collected.

There are probably three principal reasons for this increase in admissions of elderly people to psychiatric hospitals For one thing, there are more older people today than ever before. This fact alone could explain much of the rise. A second reason is that the capacity of mental hospitals has continually expanded. This means that more of the senile population can be admitted. Another factor is the change in family organization, housing conditions, and concepts of family responsibility that make children more willing to solve the problem of dealing with senile parents by placing them in psychiatric hospitals. A fourth possibility is that contemporary life may place upon elderly people increased stress of the sort that tends to create mental and emotional disorders.

Of course, we know no more about the actual prevalence of senile psychosis in the population than we do about the

less abrupt than it is for the wage earner. Even after the children grow up, she often keeps house for her husband or for herself, or in some cases may be able to help in the children's homes.

Another factor that contributes to the aging process is that of being treated as old. This can take such forms as unnecessarily preferential treatment, overprotection, exclusion from the more active sports and recreations, and behavior implying that the ideas and interests of the older people are antiquated. The attitudes of the elderly toward this treatment may range from pleasure at being shown due respect, through rueful acceptance, to deep humiliation and resentment. This "social-aging" may start at almost any period; in general, it depends on the relation between the aging individual and his younger contemporaries, involving many factors of which chronologic age is one of the least important.

Thus, our imaginary chart of the aging process can show an infinite number of curves, most of them rising through the twenties and then sloping off, none at the same rate and varying greatly in individuals.

When did you begin to think of yourself as old? Some years ago, a number of people were asked this question. Answers ranged from eighteen years to eighty-two; the average response was forty-nine. It is interesting to note that the symptoms of aging mentioned by these people were predominantly physical.

Many people, happily, are able to grow old gradually and gracefully. Physical deterioration is accepted and adjustments are made to new limitations and situations as they arise. For others, recognition of aging comes as a serious shock. This experience is often precipitated by some crisis — retirement, loss of husband or wife, loss of family home,

acute or chronic illness. In general, physicians note that these situations are crises principally to people who have had difficulty in meeting similar critical situations in earlier life. In other words, mental health in old age depends a great deal upon mental health throughout life. Preparation for the process of aging starts in youth.

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Of course, we know no more about the actual prevalence of senile psychosis in the population than we do about the

prevalence of any other mental illness. Although there are more than six hundred thousand mental patients in psychiatric hospitals, the actual prevalence is much higher.

There are two principal diagnoses for mental illness in the aged. Very few new cases of schizophrenia, manic-depressive psychoses, general paresis, or alcoholic psychosis appear after sixty-five; even the involutional psychoses decline sharply after this age. Instead, about 43 per cent of the new admissions after age sixty-five are diagnosed as senile psychoses and 39 per cent as cerebral arteriosclerosis — totaling 82 per cent of all first admissions in this age group. These diseases of old age are most commonly characterized by loss of memory and ability to think. Other characteristics found are decreased initiative, irritability, emotional instability, restlessness, and general mental deterioration. Physical symptoms are also common.

We who deal with mental health problems may sometimes place too much emphasis on mental illness. This is particularly true in talk about the aged because we are conscious of the soaring curve of admissions to mental hospitals for senile psychoses. In order to get better perspective on this problem of mental health in the aging population, perhaps the needs of the average or "normal" person over sixty-five should be considered

HEALTH NEEDS

One of the basic needs is health. Illness, and especially chronic illness, becomes increasingly important as age increases. According to the National Health Survey of 1935-36, the annual frequency rate for disabling sickness was more than 60 per cent higher among people over sixty-five than it was among the general population. The average duration of these illnesses was 131 days per case for older

people, as compared with fifty-eight days for all cases. The effect of these prolonged illnesses on the mental welfare of the aged is direct and obvious.

Of recent years there has been an increasing interest in geriatric medicine. It has been surprising to learn that the rise of life expectancy *applies to the infant*, rather than to the grandfather. Today the person of sixty-five has little chance of living much longer than did the person of sixty-five in the year 1900. Victories over fatal illnesses have applied primarily to those attacking the younger population, while heart disease, cancer, and other so-called degenerative diseases have been checked only slightly. Intensive research programs are now in progress, however, and great advances will be made against these diseases.

Meanwhile physicians are also attacking the general medical problem of the aged individual, as well as his specific ailments. There is little pleasure in surviving a series of diseases if the aching and burdensome body is doomed to spend the rest of its days in inactivity. Extended longevity without health is a sorry gift. Gradually the idea of periodic health checkups is developing, and of planning for health in old age through medical correction of failing eyesight, through education and dental care that can help assure a well-rounded diet, through guidance in the amount of exercise – in short, a full program for maintaining the sound body that is so important in maintaining the sound mind

Closely allied to the purely medical needs of age are the needs for nursing and other care for people who are disabled by long-term illnesses. The extent of chronic illness among the aged, together with its duration and a relatively low income, makes this an extremely important problem.

One encouraging development has been the plan devel-

oped at Montefiore Hospital in New York City for providing good medical and nursing care in the home. Although this idea was instigated by the wartime shortage of hospital space and nursing personnel, the Montefiore plan does more than take chronic invalids out of hospital beds needed for acute cases. It brings care of the ill back into the familiar and friendly atmosphere of the home — an atmosphere that can be familiar and friendly because the plan arranges for home care without saddling the family with an insupportable burden. Under the Montefiore system, selected cases are returned to the home after the groundwork is carefully prepared by the doctor, the social worker, and the nursing staff. The family is instructed in routine care; a visiting nurse comes in as often as needed for special care. Because this program was developed for low-income patients, the hospital also arranges and pays for housekeeping aid when necessary. In two years of experience this Montefiore plan has not only proved to be inexpensive — less than a quarter of the cost of hospital care — but extremely well-received by both patients and families. The District of Columbia has recently started to work out a similar plan, and the idea will undoubtedly spread.

In the Montefiore plan, special emphasis is put on rehabilitation, although many of the elderly patients have been cancer cases. Throughout the country, however, relatively little has been done to develop medical rehabilitation services for the aged, largely because of pessimistic attitudes among physicians, families, and the aged themselves. There is no doubt that many aged persons, even after relatively prolonged illness, can be taken out of their beds and wheel chairs and restored to more or less active life through the resources of modern medicine — surgery, prosthesis, dietary support, and, most important, mental

health guidance to restore the will to live and a sense of purpose in life.

NEED FOR ECONOMIC SECURITY

Another basic need for the aged is for economic security. Available statistics reveal an extremely unhappy situation. In 1949 only one-third of the population over sixty-five years of age were employed or married to people with jobs. Of the rest, 23 per cent received old age assistance, 24 per cent had social insurance income, and the rest lived principally on savings or on private pensions or with relatives. Even in recognizing the fact that many people have more than one source of income, it is evident than many must live on very small budgets. For those persons over sixty-five who had any income, the average, in 1948, was reported to have been less than $1,000, barely 40 per cent of the average income in the period from fifty-five to sixty-four years. In the older age group, of course, family financial responsibilities decrease, but medical expenses rise sharply. To enjoy retirement and the fruits of a long life on such an income requires ingenuity, to say the least.

What can be done about this mental health problem in which millions of elderly people are forced to lower their living standards in the evening of life or to accept support from relatives?

Increased employer responsibility for aging employees, as demonstrated by pension plans, is one type of solution, although it can penalize older job hunters. Liberalization of public assistance programs also helps to lift the financial burden on the family, as well as on the aged, and thus relieves family tensions Old age insurance is *another* solution which provides, at least for those in covered employment, a minimum income which carries no stigma of

charity or pauperization. Obviously, it does not provide a complete solution, as the current levels are far below actual needs for adequate support. Nor can these problems of economic security for the aged be solved by a mental health program. Nevertheless, we in the mental health field can and should point out factors in various systems of financial support that affect the mental health and effectiveness of the older population.

NEED FOR USEFUL ACTIVITY

The third fundamental need of the aged is for useful activity. This need, unfortunately, is often not recognized by the aged themselves. We probably all know men and women who looked forward eagerly to retirement but *found time hanging heavily after only a few weeks of leisure* — so heavy in many cases that this sudden inactivity precipitated severe emotional crises.

Probably the most satisfactory activity is gainful employment in work suited to the abilities of the aging individual. Hobbies and voluntary services can be absorbing and highly productive, but the added satisfaction of continuing to earn a living is very important to most people. For example, the former breadwinner finds his retirement bringing loss of status both as husband and father. The wife retains her job as homemaker; a child becomes the chief family support. Either of them may supplant the father as the real head of the family.

There is discrimination against the older employee both in pension and retirement systems and in hiring policies. The pace of modern industry and business has put a premium on youth. Furthermore, rapidly changing techniques make it necessary for the worker in most fields to make sharp readjustments and continually learn new skills.

Rightly or not, many employers feel that older people cannot or will not make these adjustments. Furthermore, pension schemes penalize the older worker when he must seek a new job, because the employer is naturally reluctant to take an employee who will be eligible for retirement after only a few years of service.

As Dr. Edrita Fried, of McGill University, has shown in a study of attitudes toward retirement among people of various socioeconomic groups, this burden of joblessness is particularly hard on the group lowest in the economic scale. Few of the people she studied in this group had retired voluntarily, and most of them desired intensely to get back to work. Inactive status (no regular activity, gainful or otherwise) was several times as prevalent in this lower group as in the middle and upper class groups. Similar conclusions may be drawn from a study made eight years ago by the Bureau of Old Age and Survivors Insurance, which showed that only 5 per cent of recipients had retired voluntarily Half of them had been laid off, and the rest had been forced to retire because of ill health.

Solutions for these problems may be found in a number of ways One is by effectively proving the value of older workers for their skill, experience, and stability. Rather than simply relegating the older worker to the job of night watchman, many firms have been able to work out plans for shifting such employees to jobs which make use of their full capabilities. In this field, more research is needed on tests that will reveal the abilities of older workers and on job analyses that will show what tasks can profitably be performed by these people.

It may be desirable to make the retirement age more flexible. Of course, it must be admitted that the arbitrary retirement age of sixty-five has at least the virtue of imper-

sonality; to screen aging employees by a series of tests raises more touchy questions and for this work much experimental work needs to be done on construction, validation, and administration of such tests. That this problem is not insuperable, however, is demonstrated by the experience of the International Typographical Union, which provides in all contracts that no employee can be retired because of age without first being given a medical examination.

Part-time work can be another way to alleviate the problem. Again, an example is the International Typographical Union, whose Big Six Local in New York permits members to continue to draw union retirement benefits even though they work only one or two days a week — an excellent method of making the transition to retirement easier, both economically and psychologically.

Another approach to keeping people in gainful employment is by helping in the adjustment of the older job seeker. Forced to seek employment in the later years, older people often are handicapped by gray hair and become disheartened by repeated failures. The National Employment Service of Canada has shown, however, that counseling of the older person seeking work can be highly effective. A special office was established in Toronto for people over forty-five. Of 550 men, more than 300 obtained jobs after counseling, most of them after a long period of unsuccessful job hunting. The aims of this counseling were to help the men reorient themselves to changing employer needs, to help them appraise themselves and their assets, and to raise their morale.

Solution of the problem of the older worker is far from simple. It reaches into many fields — employer attitudes, vocational training, pension and retirement systems, and others. Like the problem of economic security, it cannot

be solved by a mental health program alone. Those in the mental health field can, however, indicate the needs of older workers and would-be-workers, their assets and their limitations, and give the benefit of specialized knowledge and points of view.

While we recognize that many older people want to work, can work, and do continue to work, we also recognize the fact that many are unable to continue earning or, as in the case of housewives, have never been part of the labor force and cannot be expected to enter it after sixty-five. Useful or creative activity, however, is essential to almost all normal people. After the years of gainful employment are over, a person should be able to work more intensively at gardening, model-building, or some other activity which gives him satisfaction The businessman who retires, either voluntarily or at his doctor's orders, should retire to *something*. The housewife, particularly if continuing household duties do not occupy her entire time and energies, needs to branch out into other activities such as hobbies or voluntary organization work.

This is a need in which the community can do a great deal to help older people. Companies which have the resources can actively encourage older employees to develop outside interests as they approach retirement age. They can also develop preretirement counseling services. Churches can help through the pastoral counseling activities of their clergy and also by developing useful group activities that have special appeal to older members. Schools and universities are beginning to offer courses of interest to older people Possibilities here are tremendous in education for vocations, avocations, and general-interest fields. Courses can also be used to help older people to understand themselves and to adjust to life in the later years,

as marriage courses are designed to help a younger group in personal and social adjustment. Fraternal organizations and clubs can develop activities in which the more elderly will not have to compete strenuously with younger and often more aggressive members. These organizations can also keep the needs and interests of the older group in mind when planning their general programs.

It must be remembered that the cost of leisure activities to the elderly person is an important consideration. For many people the need for these nongainful occupations rises as income falls. The expenses of equipment, tools, and club memberships can transform many leisure activities into unattainable luxuries. Engaging in useful activities can be an economic problem, as well as a problem of changing old habits and developing new interests.

One extremely promising community development, appearing chiefly since the war, is the day center. One of the best known is the Hodson Community Center in New York City. Situated in a low-income area of the Bronx, it is open every day from nine to five o'clock as a place where older people in the neighborhood can go to engage in hobbies, organize and carry out activities, or just sit and chat with old and new friends. The problem of older people in cities is particularly important since so many live alone or in apartments where they are left by themselves much of the time while the younger members of the family are at work or in school. Mr. Harry Levine, of the New York City Welfare Department, which sponsors the Hodson and other day centers, estimates the cost of such centers at about $20 to $40 a year per person, including adequate space in a convenient location, trained leaders, and facilities for creative activities. Against this cost, may be set the almost inestimable value demonstrated by Hodson Center, which reports

a notable reduction in medical care needs of participants, most of whom are public assistance recipients, and not one case of hospitalized mental illness among any of the hundreds of elderly people who have been coming to the Center

Philadelphia is another city that has pioneered in recreation service for elderly people. Most of its "golden age" neighborhood clubs are partly supported by voluntary organizations and partly by the municipality, as are the New York centers.

These organizations do not function as old age counseling services, although they may provide such aid or act as centers for referral to these and other types of community social services. *Their main function is to provide* an atmosphere where older people will be free to make and to maintain social contacts, revive interests which have atrophied with disuse, and find new activities which can give purpose to life.

NEED FOR A HOME

Since we are listing the needs of the aged, we can group a complexity of needs together under the heading of the need for a home. This means not only the physical need for shelter but also the need for a place of one's own which is familiar and secure, adequate for social and recreational activities, and preferably a center of family life.

Where do the older people live? According to the 1940 census, only 4 per cent live in homes for the aged, psychiatric hospitals, nursing homes, or other institutions. This is a fact to be remembered when the problem of institutional care for the aged tends to overshadow the problems of the other 96 per cent who are members of households. The census also reveals that three-quarters of the aged live as

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head of the household or as wife of the head. This last fact must be qualified by the knowledge that a "household" may be merely an aged couple or an individual and also by the fact that many of those reported as household heads may not actually be the sole or even the principal breadwinner. As age increases, a higher and higher proportion of these elderly household heads are women who have survived their husbands. In the population over sixty-five years of age about two-thirds of the men still have wives, but only one-third of the women have husbands. Married companionship in old age is clearly a more serious problem for women than for men.

We are all familiar with the situation of aging parents left stranded in the old home, which is too large and hard to maintain after the children have grown and moved away. Builders are now putting up "expansible" houses with an attic that can be finished off as a bedroom for a growing family. Probably, "contractible" houses for the contracting family are also needed. Of course, the aged parents can, and often do, move into smaller quarters, but this change from familiar surroundings at a time when other difficult transitions are being made can cause severe emotional strain. Furthermore, the alternatives — an apartment in an unfamiliar neighborhood, a furnished room, or a home for the aged — are often unsatisfactory. One solution, which has been tried most extensively in Europe, is special housing for the older citizens — small cottages or apartments, convenient to shopping and recreation facilities and designed for ease of access and housekeeping. There is no general agreement as to whether this housing should be designed for colonies of older people or built among homes for younger families. Certainly we need more studies of housing preferences, such as the one made last year of 1,900

old age assistance recipients in Somerville, Massachusetts. This city provides one of the highest average allowances in the country, and one may assume that recipients are relatively free to live as they choose. Of these 1,900 people over sixty-five, 40 per cent lived in apartments (even though most of them did not live with their children), 30 per cent had boarding room arrangements, and only 14 per cent lived in single rooms. Clearly, there is a dominant preference for living arrangements that make social life more possible. There is no doubt, too, that the aging population and the changing concept of family life demand that, for the mental health of older people, serious efforts be made to provide something better than furnished rooms and inadequate institutional accommodations.

NEED FOR INDEPENDENCE AND SELF-RESPECT

The last basic need of the aged that I shall mention is independence and self-respect. This need runs through all of the other needs discussed, but it is so important that it is worth emphasizing for itself. Dr. Lillien Martin, that remarkable California psychologist who entered the field of old age counseling when she herself was more than sixty-five and continued this work until her death at ninety-two, found many cases in which old people were forced into dependency and loss of self-assurance by their children. Children, she reported, often coddle aged parents, not only in concern for their health, but also because they want the parents to live restricted lives in which they will not interfere with their conduct. Dr. Martin observed, however, that many old people were remarkably tough and capable, even with physical limitations, when their independence had not been blunted by oversolicitude. This observation should be borne in mind by people who work with the aged

in agencies and institutions, as well as by the children of aged parents.

SPECIAL NEEDS FOR THE MENTALLY ILL

In addition to these basic needs of the aged, I shall also consider briefly some of the special needs of the aged mentally ill. It has been asserted that many of the senile cases in psychiatric hospitals are there merely because they demand care and patience that the family is unwilling to give. One may ask, however, just how much of a burden the younger generations should be expected to assume in the care of aged relatives. We must face the realities of the present-day situation in which the presence of senile relatives, who are difficult to get along with and whose welfare demands constant care and supervision, can make normal living impossible for the rest of the family, including growing children who distinctly have their own rights. Provisions for institutional care are obviously needed for at least some of the senile aged.

One must ask, however, whether psychiatric hospitals are the best place for these old people, many of whom are only mildly disordered. Many hospital administrators feel that their institutions, which should primarily be treatment centers, are rapidly being transformed into homes for the aged. It has been proposed that special institutions be provided for older mental patients. Dr. David Boyd, of the Mayo Clinic, has recently presented a most attractive plan for such institutions to supplement the present state psychiatric hospital systems. These would be built in rural areas, using a colony or semivillage type of construction. They would provide for active community life and afford facilities for recreational and occupational expression. An infirmary division would give nursing care for those who

needed it, while those with psychoses or serious behavior disorders—and they are relatively few—would be cared for in the regular state psychiatric hospitals. As Dr. Boyd pointed out, the magnitude of such a project is appalling when one considers the vast numbers who would be eligible and who would wish to enter such a home. It is, however, certainly a constructive suggestion and worthy of consideration as a possible alternative to our present muddling policy. Of course, many practical difficulties come immediately to mind. Aside from the great expense to the states, one may also wonder whether such institutions could be staffed with well-trained and properly enthusiastic personnel. This consideration is particularly important in the minds of hospital administrators who have seen how staff members tend to avoid duty in the senile wards in preference to work with the more active cases. On the other hand, an opportunity to do more constructive work with aged people might bring new interest and enthusiasm to this field.

Another important fact must be considered. Today it is recognized that, even in extreme old age, mental illness does not always have an unfavorable prognosis. True, a great many cases have an organic basis and will follow a continued and inevitable down-hill course. The physical deterioration seen in aged brain tissues upon autopsy, however, does not always correlate with the degree of clinical deterioration. Emotional crises, prolonged environmental stress, and other psychological and social factors can affect the old as well as the young. Given appropriate treatment and relief from major environmental stresses [illegible]

[illegible] significant [illegible] of elderly mental patients whose symptoms have been improved by proper nutrition. One or more of such

factors as lack of teeth, badly functioning digestive systems, and low income may cause serious vitamin deficiencies which, in turn, can cause mental aberrations.

One can also point out that many senile patients, while they cannot be fully restored to their former mental states, certainly do not need continued psychiatric care. In many cases the sudden appearance of senile mental illness, set off by some crisis, is relieved by hospitalization and therapy. If the source of strain can be removed the patient can often return to family living with excellent adjustment to a quiet routine. In some cases, of course, return to the family is impossible, either because the patient needs more nursing care than can be given or because sources of emotional tension cannot be removed. Such a patient often must remain in the psychiatric hospital, because there is no other alternative, but can usually adjust successfully to living in a foster home or home for the aged. The analogy between this type of case and the more familiar cardiac case is clear. In some cases the individual must limit his physical activities to live successfully with a crippled heart, in the others the individual must not put too much strain on his mental and emotional capacity.

CONCLUSION

I should like to say that not only we who are professionals but also the public as a whole need to change many of our ideas about the possibilities of fruitful and enjoyable life in the later years. It is encouraging to know that we now have better tools with which to attack these problems – in increased understanding of mental and emotional factors, in wider knowledge and use of medical care to relieve the physical manifestations of age, and in increasingly responsible attitudes toward socioeconomic problems. It is also

extremely encouraging to see more and more effort applied to finding solutions for the problems of the aged. Several states, notably New York, have undertaken intensive studies of the older part of the population. The National Conference on Aging, held in August, 1950, under the auspices of the Federal Security Agency, did much to focus nationwide attention on these problems and should help to lay the basis for sound planning throughout the country.

From there it is necessary to go on, in communities throughout the country, large and small, to develop programs for meeting the needs of the aging population. It is partly a research task to formulate questions and to find answers that can guide planning toward maximum effectiveness. It is also an educational task to help modify many of the current ideas and attitudes toward aging that are held by professional workers, employers, fellow employees, friends, families, and the aging persons themselves. In addition, there is the task of evolving services and facilities to help meet the needs of this unit of the population — as we are working with such a measure of success to meet the needs of children and of other groups.

From the point of view of mental health, the central problem is to give older people a sense of participation and continued purpose in life. Too often, as one expert on this subject has said, the aged are "persons without a past which has anything to do with the present in which they are living." They too often find themselves beaten down by poverty and illness and pushed out of the main stream of life. Our task is to help aging people meet changing biological, social, and environmental conditions and to assist them in the successful emotional adjustment to the oncoming years.

Those who have not yet passed that fateful sixty-fifth

birthday will have to live with increasing numbers of old people. Those who manage to survive this chronological trauma will still have to get along with themselves and with those about them. But, no matter where we stand on the path through life, we cannot permit ourselves to think of one group as a burden on the other. The goal must be to make it possible for all age groups of the population to live full and productive lives, maintaining throughout the sense of purpose and accomplishment without which life cannot bring true satisfaction.

CHANGES IN EMOTIONAL NEEDS WITH AGING

BY MOSES M. FROHLICH

Moses M Frohlich, M.D, is director of the Veterans Readjustment Center and associate professor of psychiatry at the University of Michigan. During World War II he was a lieutenant colonel in the Army of the United States for three and one-half years. Three years of that time he spent overseas in charge of the psychiatric division of a general hospital. Dr. Frohlich contributed a chapter entitled "Mental Hygiene of Old Age" in the book Living Through the Older Years.

WE ALL KNOW that as we grow older we undergo changes. When we hear the remark, "Oh, he is getting old," it generally means something fairly definite to us. A number of scientific studies, especially in more recent years, have given a fair amount of information on what happens to us in various respects as we increase in age. We know, for instance, that the structures of the body shrink and become drier. We know that tissues lose elasticity and show other changes. We find that the glands of internal secretion produce less hormones, that general reactivity is decreased, and that we have a harder time maintaining the various equilibria within our bodies. Aside from studies relating to the structural or physiological changes with aging, there are also those which pertain to various social and economic situations which impinge on the man or woman growing older in our civilization.

These changes in our bodies, functions, capacities, and

situations, are of course, related to changes on a psychological level. They are reflected in mental life and must be associated with changes in emotional needs. This interrelation between the various external and internal changes occurring with aging and our psychic reactions in later life is the topic of the present discussion. Our major question is: What happens to our emotional needs or drives as we grow older?

EMOTIONAL NEEDS AND AGING

This problem is not an easy one. Little has been written about it and the isolated bits of information available are widely scattered. I know of no complete studies regarding it and have chosen this topic not so much because of any special knowledge I possess, but because of a desire to learn something about it. We might perhaps first approach it best by isolating some emotional needs or mental attitudes and attempting to follow their modifications through the course of our life. I have chosen our sense of power, attitude toward our bodies, aggressiveness, social needs, and erotic strivings for such an examination.

Changes in need for power. Our sense of power or strength, or importance, is paradoxically the greatest in the first months of existence, when we are actually completely dependent and helpless. Even at two or three, we can still conjure up things and perform any feat merely by wishing it, saying it, or imagining it. We struggle against the limitation of our sense of power which reality imposes and generally give up most of our interest in Superman or the Lone Ranger late in our teens. From day dreams, we shift our interests to real accomplishments and derive increasing satisfaction from dealing effectively with real problems. In

our childhood, we seem to be driven to experiment with, and to practice, various physical functions and to derive satisfaction from exploring and investigating our surroundings. In middle life, we are enterprising, inventive, relishing the use of our strength, dexterity, and knowledge in the manipulation of our environment. In later years, we are likely to be more concerned with securing and main taining what we have and are likely to resist any change o innovation in our circumstances. With aging, our inter est in exploring and learning new things diminishes, inven tiveness decreases, and new conquests of our surrounding calling for a test of strength are usually avoided. With thi goes the subjective feeling of need for caution, fear of ir adequacy, and some uncertainty about our capacity to cor trol situations. The striving for power, strength, and co trol, however, does not disappear. Though generally w tend to accept our state of lessened power and adjust well t it, many may temporarily try various means of preservir what power they had and may become disturbed abo losing it. The need for it is still present even though i strength appears to be quite attenuated.

Changes in body concept. The conception of our own bodies and the attitude we have toward our physical selves also undergo considerable change. The early development of this body image or body scheme of ours is one of gradual limitation and delineation of our own selves from the surroundings which appear to be merged with us in the beginning of our lives. As youngsters, we derive a great deal of satisfaction from our bodies. We take increasing responsibility in caring for ourselves and gradually abandon the fiction of being invulnerable and of having no real flaws in ourselves. This development

is marked by some anxious periods, with vanities and concerns about ourselves. In these periods we seem at times to be fearful of losing, and at other times almost anxious to forfeit, certain parts of our bodies to which we ascribe disturbing or dangerous qualities likely to disrupt our harmonious relationship with others. In our middle maturity we tend to have a much more realistic attitude toward our bodies and in health we accept ourselves as we are quite readily. We still derive a good deal of satisfaction from various physical activities and perceptions. As we grow older, however, the pleasurable physical sensations diminish. Eating, sleeping, movement, and other physical activities become less satisfying and may at times be actually somewhat unpleasant or even painful. The concern about our physical integrity seems to become diffusely spread to various parts of our bodies. Subjectively, we tend to deprecate ourselves and to feel skeptical of our physical capacities and of control over physical functions. Again, there may be a temporary struggle against these feelings during that critical period which is often referred to as the "change of life," when we may unrealistically deny any change, may become preoccupied with various physical functions, or show exaggerated concern about our health. Eventually, we adjust to the new situation in which we still seek satisfaction from our physical selves on a greatly diminished level.

Changes in aggressive behavior. In regard to our aggressiveness, we find that at first it is quite untrammeled and directed largely toward those objects in the world around us which are needed for our satisfaction. A baby aggressively demands attention and food, actively seeks and sucks the nipple, and later bites various objects. It screams or has

temper outbursts when frustrated. To satisfy his needs a youngster may be either aggressive and even destructive in reality or may resort to his fantasy to overcome or revenge frustration. At the expense of various uncertainties, timidities, and anxieties, he gradually learns to limit this aggressiveness and to transform it into the more useful activities of middle life. As adults, aggressiveness is usually well in control, and normally we employ it through appropriate actions in the active pursuit of goals needed for our satisfaction. In older age we tend to be more patient and tolerant, more accepting of frustrating situations, and much less apt to display aggressiveness in our strivings. At this time we are more likely to turn our aggressiveness against ourselves, which may result in minor ailments, various aches and pains, or in some dissatisfactions and concerns about ourselves. The pathological situation of actual suicide is relatively more frequent in the later decades. There may be a transitory period of increased aggressiveness for a time with an adjustment to a more passive attitude later. Some aggressive manifestations and hostilities to others as well as to ourselves may remain, but general decisiveness and aggressiveness appear greatly attenuated when compared with earlier periods.

Changes in social needs. If we examine our attitudes or needs with regard to other people, we find that from the time when we cease to be *actually* a part of mother, we gradually decrease our emotional involvement with her. Slowly and not without many stresses, we *give* up our selfishly possessive attitude toward our parents and our demanding and parasitically dependent relationship to them. We pass through periods of strongly mixed feelings toward members of our family and eventually manage to moderate and

control them, usually, not until after a final upheaval in adolescence. Our interests spread beyond the family circle, and we become independent individuals. Our feelings toward people become more definite. In maturity we can be tender and generous, or firm and opposed to others; we can accept things from them or give things to them without feeling any change in our mutual independence and basic equality. We derive satisfaction from contacts with others and seek to associate with them. In later years, sometimes after a period of increased concern about our relationship to other people, we eventually find our interest in them much less intense. There is a relative withdrawal from close involvement with others, and we are more likely to prefer isolation to interpersonal intimacy. We tend to pay more attention to our own pursuits or routines and may show again increased interest in ourselves through introspection or by reminiscence. We still want someone to listen to us, but we are not too concerned how greatly we impress him. We still seek and need affection and companionship, and all they imply. We are still unhappy when we do not get these things, but our striving for others is certainly lessened in degree. Although there are instances of intense love affairs in later years and not too rare examples of an older person not surviving long the loss of a spouse, it is still generally true that our feelings and interests toward other people become less intense.

Changes in erotic strivings. Our erotic feelings and satisfactions are so diffusely scattered in early life that we scarcely recognize them as the precursors of later sexuality. We know, however, that erotic drives manifest themselves in childhood through various activities in connection with different parts of the body. Here, too, our development,

during which we limit or outgrow the early modes of erotic gratifications, is marked by periods of stress and strain. Eventually, these drives become centered around our mature sexual activity and on the sexual organs proper. This mature sexuality is certainly compatible with the procreation of our species and appears to be designed for this purpose. When we grow older, we experience a diminution of the intensity of interest in sexual activity. This interest usually persists for many years after we have lost our procreative capacity, but the pressure behind the drive is markedly slackened. Again, we may experience an apparent increase in interest during the temporary state of transition. We may see, too, in old age some rekindling of infantile sexual interests or some return to immature types of sexual activity. For most, however, there is merely a slow and gradual diminution of mature strivings.

The above effort to separate individual emotional attitudes or strivings is of necessity somewhat artificial, for in actuality they are not separate entities but intimately interwoven. The attempt to follow each of these components of mental life through its life-long changes must have been schematic and perhaps somewhat abstract in such a brief review. I have purposely avoided the many personal variations, trying to follow the main stream as rapidly as possible and leaving the shores and tributaries unexplored. This procedure has, however, been useful for our purpose, for it has emphasized the similarities in the gross course of the attitudes with which we dealt. We saw in all of them great strength, but considerable diffuseness and some confusion in the beginning of our lives. We saw a gradual, perhaps somewhat stormy, delimitation and concentration of the various drives on more specific, one might say more useful, forms of activity without any significant loss of the strength

or intensity of their motive powers. Later in our lives, we saw a persistence of these drives but an apparent attenuation of their force. We saw also that there was likely to be a transitional period of stress between the adjustment of maturity and that of later years. These conclusions are not particularly surprising. We may summarize them as dividing life into periods of development and preparation, of fulfillment through accomplishment, and finally of relaxation and holding to past achievements. This cycle of development, maturity, and involution, which is so frequently repeated in nature, appears to repeat itself in all the particular mental attitudes and strivings that we reviewed.

FACTORS RELATED TO CHANGES IN EMOTIONAL NEEDS

Physical. Another approach to the problem of changes in emotional needs with aging might be made from the point of view of the possible causes or factors making such changes necessary. We might start with the physical alterations in an aging individual. We know that the physicochemical changes which involve bodily structures and endocrine glands have a definite effect on physical functioning. With aging, agility, responsiveness, and strength diminish, and capacity for exertion and ease of recovery is lessened. There is slowing in such functions as memory, learning, adaptation to new situations. There is also likely to be some impairment of the finer muscular and sensory controls as well as of the controls of mental reactions. Various tasks and activities become more strenuous, more difficult, or even impossible. Of necessity, we must reorganize our lives to fit these changes in functioning. We begin to avoid new situations, particularly those associated with stresses, and tend to adhere to the known and tried conditions with

which we have dealt successfully before. We avoid those tasks which have become difficult and seek to substitute for them activities which are more compatible with our actual functional capacity. We tend to become more cautious and more conservative in our attitudes. We may become anxious and impatient in the face of anything which deviates from our routines and imposes adaptive strains upon us. We tend to shift from physical exertions to pursuits of a more intellectual or spiritual nature and are likely to transfer interest from the immediate family to broader social horizons. From the active role of a doer of things in our middle age, we tend to shift to a position of watching, teaching, advising, and directing in our older years. Contacts with others may become risky for us, and we may tend to withdraw into a kind of isolation. Contrarily, as a result of physical failure, we may seek the protection of others and may actually become dependent on our younger fellow men.

Cultural. The social or cultural attitudes toward old people and aging must also have an effect on our emotional needs. There is considerable variation within our culture in regard to these attitudes which affect the opportunities or their limitations for older people. The situation for a professional man differs from that for a day laborer, for a farmer from that for a factory worker, for an older housewife from that for an unmarried woman. These differences affect not only economic situations, possibilities for work and for usefulness, and the material phases of our lives, but also many aspects of our relationship to other people as well as our own feeling toward ourselves. The social attitudes toward the aged and their cultural position will determine to a considerable degree what role we may seek to play in

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difficulties, frustrations, inner conflicts, and emotional illnesses during the later years are a direct result of our attempts to mold ourselves according to the concepts of being old which we have developed in the past. Problems of this nature can often be successfully influenced by psychiatric treatment, by various group activities of older people, and by such educational efforts as talks, books, or institutes.

Instinctual drive Factors inherent in our physical changes, cultural attitude, and personal developments certainly modify our needs as we grow older. Some of the changes in our strivings would occur even if there were no other factors present; that is, even if we assumed that our instinctive drives did not themselves altar with aging. The question of whether there is any change in the inborn instinctive bases for our striving and needs has been hardly dealt with in the literature, and much investigation is needed in this field. Our instinctive drives are derived from our physical functioning. It is inconceivable that all of the somatic changes occurring in old age should not be reflected in changes of our instinctive strivings. Our survey of the several strivings and attitudes seems to indicate that such a change does, in fact, exist and that it consists primarily of a quantitative diminution. Some rearrangement and change in relative strength of the various component needs is also suggested, but predominantly there appears to be a lessening of intensity or urgency of the drives. Long-term, intensive studies of aging people could throw much-needed light on what happens to our instincts. The few reported cases of psychoanalytic investigation of older people indicate that the dynamics of our mental functioning are not markedly changed with age, though there is a somewhat greater rigidity and more need for support in older patients.

older years, or, perhaps more correctly, what role we are permitted to assume. Many of the frustrations and satisfactions of old age depend on cultural situations. In different cultures the roles of the aged vary considerably. In each, however, including our own, the person growing older must adjust himself as well as possible to the place assigned to him by the social forces around him. The relationship of different generations to each other is also determined primarily by cultural influences. The Chinese endow the oldest members of the family with great power over the younger generations, whereas in our country, we tend to be mildly deprecatory and at best tolerant and protective toward them. Aside from the general cultural determinants of what attitude exists between people and their parents, there are, of course, the personal factors stemming from the lifelong history of the relationship of the particular parent to his children.

Personal. Our personal attitude and adjustment to our own old age is also affected by our individual past history. Each of us has his special problems and his own modes or skills ot dealing with things which have developed through his lite. These factors, originating in our different inheritances and past experiences, will vary the reactions in our later years. Our personal attitude toward aging, however, is also a reflection of the cultural attitudes in our society. When we grow old, we tend to treat ourselves in accordance with our own attitude to the aged. Our strivings, activities, and restrictions on what is permitted and desirable and our response to the various feelings within us will be determined to a considerable degree by our personal attitudes toward being old. It is in this sphere that educational action shows the greatest promise for usefulness to the aged. Many

stated to be the continuation of our species. What we know of our life pattern, as modified by our cultural institutions, seems certainly compatible with this aim. In our civilization, preparation for the production and the rearing of children is long, and the parents whose job it is to prepare their young for progeny spent many years in this activity. Before our children can establish themselves independently and begin to have children of their own, most of us have reached late maturity. When we become grandparents, many of us still need to contribute much direct aid to the security, comfort, education, and well-being of our descendants. At this time, however, our major function in the biologic aim of maintaining our species may not be directly connected with our children or grandchildren. It appears to shift to the guarding and preserving of our culture and its institutions. The interest that older people show in various civic, social, and philanthropic affairs, in politics, and in religion seems to be a natural outgrowth of this biologic function. So, also, is the conservatism of the aged, although in both instances other factors are present as well. In our society, the task of each individual of keeping man and his institutions going has been prolonged by the complexity of our civilization. Our relative longevity is certainly more needed by us than in most primitive societies, and the character [illegible] of its institutions will c[illegible] by our increased average length of life. But even in our civilization, each of us eventually fulfills his part in the long chain of individuals who have kept our species going and so ends his biologic purpose in life. When this is done, our fate is death. There have been various attempts to increase our life span. Although our average longevity has shown marked improvement, it certainly can be still further in-

These cases, however, do not permit us to draw any conclusions in regard to any fundamental changes in the strength or type of our strivings. Observation of committed psychiatric patients over periods of many years and the observation of patients with personality disorders show a lessening of the intensity of emotional disturbances with age and some leveling of the abnormal manifestations. This occurs in spite of a failing physical apparatus and a diminishing capacity for control. It appears to support the hypothesis that the strength of our instinctive drives decreases as we grow older. Statistical studies of criminality indicate a diminution of all crimes in the later age periods. Cross-sectional studies of people of different ages by means of various psychological tests also suggest a diminution of interests, of conflicts, and most likely of the drives which underlie them. Surveys of biographies of outstanding individuals who have reached advanced age and comparative studies of the lives of various animals also appear to confirm that our activities, achievements, and demands, all of which are ultimately derived from our instincts, reach their peak in maturity and diminish with aging after that.

There is a popular conception that as we live, we wear ourselves out. The phrase "burning the candle at both ends" is related to it. This has found an echo in some theories about instincts, namely, in the suggestion that we are endowed with a certain amount of energy or vital force at the time of birth, and that we gradually use it up as we live. How correct this theory may be, no one knows. Although it sounds quite plausible, there is little evidence to suggest that the intensity or rapidity of any phase of our lives has any relationship to longevity or to the vital forces which remain with us in our advanced years.

The biologic purpose of our individual lives has been

cope with the problems we have. In later years when we lose many avenues for satisfaction either through our own changes or through social restrictions, when we experience a diminishing control of mental and physical processes, when we cannot cope as well with tasks of memory or learning, physical illnesses or hardships, we may readily develop a feeling of inadequacy. Stresses of any kind become burdensome and frightening. When we do feel inadequate, it means that we cannot deal effectively with some of our real external problems or that we cannot satisfy our inner needs. A sense of personal security depends on freedom from anxiety or severe deprivation. Regardless of our economic, material, or physical security, the subjective emotion of personal security depends also on how well we handle our own drives, especially in regard to others. This again relates to the balance between our various emotional needs and the opportunities or capacities to satisfy them Our feelings of adequacy or security and our self-esteem are related to our sense of usefulness which, in turn, depends on the opportunities we have of using our wisdom and experience and our remaining physical and mental skills in the fulfillment of the biologic function of our later years. The satisfaction of our needs permits us to maintain an interest in things outside of ourselves and to be active in civic or altruistic pursuits

The things we need for our satisfaction change with our aging, both in degree and in relative proportion. At different ages, different things are needed for our satisfaction, but in all ages frustration of these needs leads to unhappiness or illness. As we grow older, our biologic purposes change, our social situations alter, and we ourselves become different. Though our capacity for rapid changes in adjustment is diminished, our ability to adapt ourselves to old

creased. Whether our life span can be lengthened, however, is subject to very serious doubt. It seems as if the seed of our death is within us at birth as a common inheritance of our species and that our life span is rather well set for us with its minor individual variations, much like the relative predestination of our stature. That death, which is our ultimate earthly aim, is not only a passive wearing out of our bodies due to physicochemical factors, alone, but also has a psychic representative in the form of an instinctive force leading eventually to it was postulated by Freud on the basis of other considerations. Such a "death instinct" appears completely unacceptable to most of us, but our discussion here has certainly led us quite close to it. This problem is, however, a theoretical one and largely speculative at the present time. Only intensive and prolonged investigation can throw much further light on it.

ADJUSTMENT AND CHANGED EMOTIONAL NEEDS

From the foregoing, it would appear that as our powers of achievement and control diminish with aging, the demands we make of our bodies and minds in regard to emotional needs appear to decrease as well. Although the intensity of these needs is lessened, they are still present and must still be satisfied. A balance between our strivings and capacities or between our needs and their satisfactions must still be maintained, although its level may be different than before. It is frequently said that a sense of adequacy and security is extremely important for older people. A sense of adequacy is a subjective feeling which relates to this balance between our personal resources on the one hand and the real external problems and our inner urges and strivings on the other. It depends on our capacity to

PSYCHIATRIC TECHNIQUES IN THE TREATMENT OF OLDER PEOPLE

BY JACK WEINBERG

Jack Weinberg, M.D., holds the positions of adjunct in psychiatry at Michael Reese Hospital, attending psychiatrist at the Veterans Administration, consultant in psychiatry at the Home for the Aged Jews, and assistant professor in psychiatry at the University of Illinois. He is diplomate on the American Board of Neurology and Psychiatry and a fellow in the American Psychiatric Association. Dr. Weinberg's publications include the chapter on "Mental Health Needs of the Aged" in the 1948 proceedings of the National Conference of Social Work.

FROM TIME immemorial man has struggled with the irrational forces underlying emotional disturbances. Everything conceivable has been tried by those who have been called upon to treat human beings. Psychiatrists have gone a long way from the days when, through incantation and prayer, man tried to placate and drive out the evil spirits. We have attempted brain surgery and shock treatment, long-term psychotherapy, short-term therapy, individual psychotherapy, group therapy, various drugs, heat and cold, fire and ice, music, sociodrama, hydrotherapy, occupational and recreational therapy, total push to total regression; all have been tried, and to all have been ascribed healing powers by those who promulgate their favorite means. The confusion resulting from all of the claims becomes no confusion when one realizes that all of the above therapies have a common denominator. The common denominator is,

age is generally adequate. We may experience a critical period in our "change of life," just as we experience periods of stress in adolescence and in other transitions in our lives. Our latest readjustment after this through the eventual re-integration of our personality should lead to an acceptance of our new situation, and to an old age in which our needs and capacities are balanced, an old age full of satisfactions in which there is little fear of our ultimate death.

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of course, the therapist and the patient, the interpersonal relationship between them, or as the psychoanalyst refers to it, the transference phenomenon.

For no matter what the treatment may be, and there are, of course, valid and intrinsic values in all of the above-named methods, it is nonetheless the awareness on the part of the patient that in the therapist he has an individual who is ready to understand, willing to give and to help, which is beneficial and therapeutic. Old age, however, as any developmental phase in the life span of a human being, has specific problems which are unique to it, and to it alone. This uniqueness requires a definite therapeutic approach which is to take into consideration the needs peculiar to the aging organism. Yet again it is good to remember that the needs of the aged are the needs of the human being at any period in his life, that is, security, adequacy, and the support and interest of other people.

EFFECTS OF THE AGING PROCESS ON PERSONALITY

To cope adequately with the special demands of the aging patient we must examine the nature of the aging process and its effects on the personality. The outstanding characteristics of senescence which threaten emotional health are the physical decline, loss of erotic values (attractiveness), loss of supporting figures (family and friends), social and economic insecurity, and the gradual contraction in the flexibility and plasticity of the adaptive mechanisms. As a great deal has been written and said about the impact of these losses on the individual, I need not elaborate upon them. I should, however, like to discuss the reaction of the personality structure to these changes through symptom formation. For in the last analysis it is through the under-

standing of the principles underlying the symptoms that we can best help these people.

Psychiatrists have long since recognized that symptoms are not only expressions of a disease process but that they are also substitutions and evasive maneuvers on the part of the organism to maintain its intactness and the integrity of its ego. By ego we mean that part of the personality which integrates all internal and external stimuli and allows for unified action. It is the compromiser between our instinctual drives, with all of their irrational demands on the organism, and the moral, ethical, and cultural forces which are opposed to the chaotic expression of these drives. It is the ever alert, watchful guardian whose strength depends on its flexibility and adaptability.

The proper functioning of the ego is dependent on the physical status of the individual and on the element of hope for continued gratification, reward, and affection. In the aging person, the physical self undeniably undergoes biological changes which reduce his efficiency. He must therefore, without alarm, do everything possible to maintain a physiological balance which will hamper least his physical activities and emotional responses. Modern medicine has made the realization of this balance much more possible. No medicinal miracle, however, is available to supplement the depletion in security and in supporting figures which can feed the hope of the aging organism for continued gratification. Hope for an improved state of affairs is somewhat unreal at the twilight of life.

The decrement in personal, physical, and emotional assets and the absence of hope for a better tomorrow greatly endanger the adaptive capacities of the ego To master the threat of dissolution of its boundaries the ego will utilize all of its previously learned defenses and add some new

ones to its repertory. These defenses are easily recognized as the symptoms which arise. We label them defenses for we recognize the protective quality inherent in them no matter what the distortion from reality may be. The major defenses employed by the ego in later life are those of regression, rigidity, and the exclusion of overwhelming stimuli.

Regression is an easily discernible phenomenon in all emotional disturbances. When life situations become unbearable, when the odds against continued adjustment are increased, the organism retreats to earlier methods of adjustment. It goes back along the paths it has previously traveled with some success. It may return to a previous level of adaptation in which the organism had mastery over its environment. The path may be the familiar one of increasing incapacity and dependence on others. Thus, the familiar observation that old age is the second childhood—a childhood, however, minus the charm and grace of youthfulness and universal appeal and acceptance. An excellent example of this phenomenon is the return of the aged to earlier methods of sexual gratification, that is, autoerotic practices, exhibitionism, etc., when the normal repressive controls begin to fail them and when their advances are no more acceptable to others because of their unattractiveness.

Psychic rigidity is another characteristic of the aging person. Yet few recognize in it the dynamic principle of a defense. We live in a highly complex ever-changing world in a fluctuating environment demanding constant readaptation. To master new situations requires the greatest efficiency and integration of the ego. The decrease of efficiency of the ego in the elderly is obvious and therefore almost invariably calls forth anxiety when readjustment is necessary. To avoid crippling anxiety the aging person will

cling to the plane of adjustment already achieved, no matter how faulty. He is loath to give up automatized and familiar patterns of behavior and reacts to new situations as to some danger, with peevishness, irritability, and hostility. Change is regarded with paranoid suspicion and fear, and the individual will cling tenaciously to a world in which he has achieved his maximum instinctual gratification and his nearest approach to a mastery of his environment. This, then, is the familiar conservatism which is encountered in anyone older than we are and which we deplore.

The third outstanding defense characteristic of the ego in later life is the exclusion of external stimuli which by their confusing diversity may upset the homeostasis of the psyche. This is comparable to the exclusion of exhausting physical activity when one's heart and muscles can no longer respond to too much stimulation. The aging person gives up strenuous activity for fear that it may deplete his energy and destroy him. Psychically the aging person may do the same. The so-called inability to learn is a defensive maneuver against the expenditure of energy when the reservoir of energy is low. Visual and auditory acuity are noticeably diminished in later life. Yet there is somethin [illegible]

[illegible] interpret, and cope with new stimuli is at a low ebb. The organism thus tries to eliminate many stimuli which would tax adaptive mechanisms. A good example of this phenomenon is the familiarly troublesome symptoms of memory defects in old age. Defensively this is not only a denial of the unpleasantness of the unpleasant present, but is also an attempt to exclude from an impoverished ego external and internal painful stimuli.

All of these defenses are dynamic mental processes rather

than fixed habit patterns with organic substrata and are, therefore, not beyond therapeutic reach. For all practical purposes, however, these symptoms keep the elderly out of step with the ever-changing world and most often act to isolate them and to add to their insecurity. The therapeutic goal then is first to understand the symptoms and the nature of the defenses, then to modify, attenuate, or work for the acceptance of some of them without resigning necessarily to further decay.

THERAPEUTIC TECHNIQUES

The therapeutic approach to mental ill health in the aged is based on the psychopathology which falls into two categories — organic and functional. The treatment of the organically determined disturbances which include the presenile psychoses (Alzheimer's and Pick's disease) and the psychoses with cerebral arteriosclerosis, is mainly medical, custodial, and supportive. These patients must of necessity most often be hospitalized. It is a mistake to disrupt the balance of a family's life by the stubborn refusal to hospitalize a psychotic parent. One does thereby an injustice to both the patient and the family. For only in a hospital can the medical needs of these patients be properly met. One can do a great deal in the correction of the mental aberrations by proper diet, adequate vitamin intake, and elimination of infectious processes, and through drug and endocrine therapy to control the proper interchange of fluids and oxygen in the brain tissues. Furthermore, the tendency to oversedate these disturbed patients when they are out of a hospital setting is great. Barbituates and bromides tend to confuse the elderly patient, for they are not well tolerated, so that the result is greater restlessness, excitability, or a comatose condition.

Then too, the hospitals supply more adequate and objective nursing care. Occupational and reactional therapy as well as mild exercise can best be managed by those who are trained to do it. The belief that the family's love and affection for their loved ones will compensate for any lack of proper physical care, while at times possible, is usually untrue. Unconscious resentments and guilty feelings creep into the interpersonal relationships and all sense of judgment may be lost.

Psychosomatic disturbances, not connected with the aging process as such, are not uncommon in older people. It is important to recognize this fact for otherwise any physical disturbance will be ascribed to organic failure and decay. Treatment in these conditions should proceed along the same line as psychotherapy at any age level, with some exceptions. Caution is of paramount importance whenever stormy subjects are to be discussed. The therapist would do well at times to indicate to the patient that a discussion of topics that cause hostility can produce physical reactions. Not only is it wise to warn the patient but also any interpretations made should be cautious, noncommittal, and tentative in nature. This is particularly true in those psychosomatic disturbances in which the blood vascular system is involved.

Whenever there is demonstrable brain damage the therapeutic possibilities are of necessity limited. One can, however, help reduce irritability and mood swing through interpersonal relationship of understanding, and the conveying of this understanding, to the patient. By gentle discussion of the physiological processes one can lessen the patient's feelings of fear and the loss of self-esteem. One's own concept of one's body, and the imagery that one has about it and its function, is faulty at the very best. One can

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neurotic personality structure. It is obvious from the above that these determinations require the services of a trained individual. It should be the psychiatrist's responsibility to decide what type of treatment is to be instituted and who is to do the therapy.

When therapy is not under the direct supervision of the trained psychiatrist the following techniques should be of help:

1. Allow the patient to express himself, to talk about himself and his difficulties Impatience will be accepted as a rejection which cannot be tolerated The attitude should be one of respectful attention and thoughtful consideration despite the fact that the same problem may arise and be discussed over and over again. Empathy, the ability to place yourself in the patient's position without identifying with him, and not sympathy is of essence. The older person does not wish the other person to sympathize and pity him. He craves respect to help him bolster his self-esteem An insincerity of approach will be easily discerned by the patient or client and insurmountable barriers will arise.

2 Allay the anxiety and insecurity of the aging person by the strength that you have to bring to the situation. This requires a genuine fondness for the elderly and a willingness to help them. One must, however, be diplomatic, for they are proud and do not wish to betray weakness. Therefore, they should be allowed to gratify their dependent needs in a manner that will not make them feel that they lean on you A condescending, patronizing attitude on your part will only help to accentuate inadequacy and insecurity.

3. Help them into activities which will tend to enhance their attractiveness, physical and otherwise. As long as an individual is young he may be physically attractive. When

help the elderly person tolerate his physical decline by an honest evaluation and orientation of his organism.

The depressions of the involutional period and later life respond surprisingly well to electric shock therapy. One should not be deterred by the risks involved for they are negligible if proper precautions are taken. Patients in their eighties have been treated successfully despite some changes in the cardiovascular system. I have treated patients in their seventies with gratifying results, once I have overcome my own anxieties about their physical status.

Direct psychotherapy of older people can also be very gratifying. One must make due allowances for their reduced vigor, agility, and learning capacity. Beyond that, therapy can be conducted along the lines of therapy at any age level. The skilled therapist who knows the dynamics involved has to be more active and more direct in the treatment of older people. This is as true of therapy directed at the level of personal conflict, insecurity, and rebellion as it is true of therapy directed at one's attitudes, at manipulation of the environment, at social rehabilitation, and the like.

The question as to what type of therapy one is to employ is dependent on a number of factors. First of all, one should assess the physical state of the person and his cardiovascular system in order to determine how much the aging organism will be able to take. Second, one must evaluate the suitability of the individual for therapy from the viewpoint of his earlier adaptation and maladjustments, his capacity for establishing a workable relationship, and the degree to which all of these are modifiable. Finally, it is important to determine whether the presenting symptomatology is something new in the life of the patient or whether it is continuation of a previously long-existing

COMMUNITY HEALTH SERVICES FOR OLDER PEOPLE

BY JOSEPH W. MOUNTIN

Joseph W. Mountin, M.D., is assistant surgeon general of the United States Public Health Service and associate chief of the Bureau of State Services in that organization. As associate chief of the Bureau of State Services, Dr. Mountin is responsible for a wide variety of activities carried on co-operatively between the Public Health Service and the state health agencies. Associated with the Public Health Service since 1917, Dr. Mountin, through the varied nature of his assignments during his long tenure of service, has become an authority in many aspects of public health. He is the author of numerous studies and monographs on diverse phases of public health administration During World War II, Dr. Mountin was chief of the Public Health Division responsible for administering a nation-wide emergency health and sanitation program. At present he is a member of the Federal Security Agency's Working Committee on Aging, seeking to define the problems of an aging population and to develop a long-range approach to the solutions of these problems

SOMEHOW THE notion lingers that advancing years and progressive disablement must go together and keep in step with each other On the contrary, eminent physiologists and clinicians state that today the two need not always be associated and should become less so with the further development of medical science. My purpose is not to elaborate on these points but to discuss the kind of health organization that should be developed in each community to put available knowledge to work and to point out the ways in

that fails him, then achievement in any field of endeavor or continued productivity on a job can enhance the person's attractiveness. To be wanted for any reason increases one's self-esteem and, as a by-product, one's erotic values to others. At the same time they must be helped to accept gracefully the curtailment of activities when this becomes imperative. In that care they are to be guided into retirement to something meaningful and gratifying rather than just retiring from a job and thus from life.

4. Plan with them and not for them their daily activity when life becomes empty. One should therefore become thoroughly acquainted with the facilities that the community, church, and social agencies have established for the elderly population. At times the old person needs to be led literally by the hand to participate, mere pointing out of the presence of facilities may not be enough.

5. Finally, one must bring an optimistic attitude to the psychiatric techniques in working with older people. One must not be too easily discouraged. One should leave the patient at the end of any interview with the feeling that the contact was a gratifying experience and that something had been accomplished during that hour. Only understanding and due consideration of the validity of the feelings of the older person will and can accomplish the desired results.

sional direction. These units represent about 112 million inhabitants, or roughly three-fourths of our population. In other areas, public health service is likely to be less well organized and to be directed by a wholly untrained person or by a local practicing physician who devotes part of his time to such duties. Voluntary health agencies, especially in the larger cities, supplement the work of official organizations. Many of these agencies direct their efforts toward diseases which are especially significant for older people, such as cancer and heart disease. From the standpoint of volume of service to individuals, the work of visiting nurse associations is, perhaps, the most impressive.

The community public health organization of our country is essentially a development of this century and particularly of the last twenty-five years. Impressive as the organization really is, it has its weaknesses. Nearly one-fourth of the population lives in areas in which a full-time trained health officer is not employed; generally speaking, staffs are far below minimum standards of adequacy, especially for physicians and nurses, and more often than not programs are of only limited scope. Even today some official health departments are concerned almost exclusively with control of [illegible] tion, [illegible] ant [illegible] in these fields, however, phenomenal results have been achieved for the nation as a whole; these are so well known they need not be detailed.

Now, efforts are being made in many places to launch programs in mental hygiene, diabetes, cancer, and heart disease. From this base it should not be difficult to project broader preventive and restorative programs. Consequently, those who are primarily concerned with the health problems of older people will be furthering their long-time in-

which such an organization might be expected to function.

It is no exaggeration to say that there is scarcely a community in this country which may be credited with having made reasonable provisions for helping older citizens meet their ordinary health requirements. This is particularly true if one considers the problem from a preventive standpoint. As a consequence, there are vast areas, both functional and geographic, where greater effort is needed in behalf of older people. Fortunately, we have for guidance a broad experience in the field of general community health services; moreover, pilot programs directed toward particular problems of older people have been under way for varying periods of time. It would seem the better part of wisdom to start this discussion by examining some of these activities and the ways in which they are organized. They should provide bench marks and guide lines for the application of accumulating information in preventive aspects of gerontology.

By and large, it has been found that significant new health programs are not likely to develop and to be sustained in communities throughout this country unless there is a suitable framework of local health organization. The nucleus of such an organization is the health department. According to the best thought on the subject, health departments should be established within cities, counties, or combinations of political units which represent aggregations of population and wealth in sufficient size to make possible effective operation and stable financial support. A basic requirement is that the department be directed by a full-time health officer who has had both training and experience in health administration. In the Continental United States today there are some 1,290 local, city, county, and district health departments under full-time profes-

sional direction. These units represent about 112 million inhabitants, or roughly three-fourths of our population. In other areas, public health service is likely to be less well organized and to be directed by a wholly untrained person or by a local practicing physician who devotes part of his time to such duties. Voluntary health agencies, especially in the larger cities, supplement the work of official organizations. Many of these agencies direct their efforts toward diseases which are especially significant for older people, such as cancer and heart disease. From the standpoint of volume of service to individuals, the work of visiting nurse associations is, perhaps, the most impressive.

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Now, efforts are being made in many places to launch programs in mental hygiene, diabetes, cancer, and heart disease. From this base it should not be difficult to project broader preventive and restorative programs. Consequently, those who are primarily concerned with the health problems of older people will be furthering their long-time in-

terest if they also give some attention to their local health department — its status and its needs. Within the compass of this paper it is possible to outline only a few of the many opportunities for health promotion which might be sponsored by public health agencies. As a result of such activities, however, the need for active care should decrease in the later years of life.

ENVIRONMENT

External environment affects the health of older people in many ways. Accident prevention and control may be cited as a field of endeavor in which the health department can take leadership. Traumatic injuries are not only prevalent among older people, but the consequences for this group are likely to be severe. Injuries may rise from falls or traffic accidents, or they may be associated with employment. Because of the numerous occasions on which members of its staff visit families, the health department is particularly fitted to take care of the home accident problem. Pilot studies now under way are showing promising results in this field. Through the combined efforts of health and safety units, industrial accidents may be expected to remain at their present creditably low level. In striking contrast, the number of persons injured on streets and highways continues to be shockingly high. While this is primarily a traffic problem, yet there too the health department, through an educational program, might make some impression on the general situation.

Considerations of comfort, convenience, and health of older people, as well as opportunity for them to make positive economic contributions, call for considerable rearrangement of homes, places of employment, and facilities for recreation and transportation. These are areas which

health agencies might be expected to explore and then come forward with constructive suggestions. Some of these suggestions health departments themselves can put into effect. Others must be carried out by agencies having primary responsibility in the respective fields.

Besides the physical environment, there is, of course, a social environment. It effects, especially, the older person, intimately in his emotional and often in his economic adjustment. In great measure, it determines his contribution to family and community life. The staff of a well-organized health department is made up of persons who represent a wide variety of technical competencies — physicians, nurses, sanitarians, social workers, and others. These people have numerous avenues of contact with the individual, his family, his employer, and community agencies. The department, therefore, occupies a unique position for appraising the total situation and a strategic one for correcting at least some of its pathologic features.

HEALTH INFORMATION

Within scientific circles a significant amount of information already has been accumulated concerning the health of older people. Now that more attention is being directed to the requirements of these groups, additions to this body of knowledge may be expected in greater frequency than heretofore. Existing factual material needs to be accumulated, classified, and put in a form which is understandable to the general public. It should be made readily available to our senior citizens and be incorporated into the thinking of all persons in society, especially those intimately concerned with older people, such as members of their families, employers, and leaders of community movements. The media commonly used for imparting other subject matter

in the health field should be suitable to the hygiene of aging with perhaps slight modification. Among the media may be mentioned simple but authoritative bulletins, leaflets, exhibits, and motion pictures. These may be supplied through some scheme of general distribution, or the information may be imparted through group health conferences under the leadership of trained health personnel. Unfortunately, there is a great dearth of popular health education material focused on the health needs of older people. The radio and television present a unique opportunity for teaching many who otherwise have little contact with the outside world.

Beyond the help and guidance they may derive from general health information, many persons need more precise instruction. This may concern the health aspects of home or family situations, employment, or incapacities of particular types. Such instruction may still be given to groups who have like problems, as for example those troubled with diabetes or overweight. Much of the retraining of the physically handicapped is done in this manner. Alcoholics Anonymous has demonstrated what strength and confidence afflicted persons may derive from each other. Many observers believe this principle has a much wider field of application, especially in mental hygiene or, for that matter, in any other problem that is underlaid by strong psychological factors.

Because many elderly persons are severely incapacitated, or have deteriorated, a considerable part of the instruction must be given through personal contact in the home. Although this method is costly and lacks the stimulation associated with group action, it does afford a means of consulting with the family, which often needs help even more than does the disabled individual. The role of the health depart-

ment in this approach obviously should be a major one.

The mere imparting of information may not be enough. To many individuals must also be supplied the incentive to put information into practice. Wherever possible, the person should be encouraged to rely on his own initiative and resources.

PERIODIC HEALTH APPRAISAL

Annually, or at least every few years, persons beyond middle life should undergo a physical checkup. Their personal health habits and work load should also be reviewed in relation to their functional reserves. A thorough examination for the entire population above any given critical age would place excessive demands on the limited resources of physicians available in many areas. Moreover, it would be too expensive for a large part of the population to bear unaided. Except for a limited group who have both the interest and the funds to take full advantage of all known diagnostic, therapeutic, and restorative services, the results obtainable are almost certain to be disappointing in proportion to the over-all cost of a highly individualized scheme

Possibly a way around the difficulties of man power, costs, equipment, and time may be afforded by tests and limited examinations of the screening type. The best-known and most widely used of these is the serological test for syphilis. Part of the same blood specimen may now be used for determining blood sugar level as an indication of diabetes and for ascertaining the level of hemoglobin and of other constituents in the blood that express nutritional status. With the development of the small film and photofluorography, chest X-ray examination has come into general use. Although developed originally as a case-finding device with

respect to tuberculosis, it has demonstrated its usefulness in revealing chest pathology of other types. Equipment of proven worth for testing hearing and vision has been in use for a long time. Extensive studies are now in progress as to the significance of different blood pressure levels, the role of the electrocardiograph in routine cardiac examination, the importance of size and configuration of the heart and great vessels as revealed by X ray, and the value of instruments such as the electrokymograph for studying the dynamic action of the heart. Still other procedures, such as those for testing organ function and detecting malignancy are being developed, evaluated, and adapted to the requirements of the screening technique.

Even when applied by groups of physicians working under optimum conditions, the most precise measures available for detecting impending or slight departures from normal have a wide margin of error. Simplified methods by their very nature are even less exact. Actually, these latter procedures are not intended for definitive diagnosis, but merely to select those persons most likely to show pathology on careful examination. As medical science advances, quick methods for screening purposes may be expected to improve like their more elaborate counterparts. I think we are warranted in recommending, at least on a trial basis, limited screening procedures for groups in the general population and meticulous examination for selected individuals. This seems a reasonable and feasible plan of extending the benefits of periodic health appraisal to ever-increasing numbers of adults. For a long time one may expect sound differences of opinion as to which tests are ready for incorporation into routine application, and the levels of reaction which signify departure from normal. Only by careful studies, extended over periods of time, can such questions be answered finally.

ILLNESS AND CARE

While centering attention on positive health measures for older people one cannot be oblivious to the findings of practically all studies which show that illness increases with chronological age. This is especially true if the unit of measurement be either duration of illness or extent of disability. Through the full application of known measures, a certain proportion of these occurrences may be prevented. Research work now in progress gives a basis for hoping that morbid processes of certain types associated with aging may be stabilized or even reversed. Encouraging results obtained from the use of cortisone indicate that conquest of certain types of rheumatoid disorders may be near at hand When the mysteries of arteriosclerosis and arterial hypertension are similarity unraveled, medical science will have removed the three main conditions which are at once causative and complicating factors of aging. While one may entertain high hopes for the future, illness now figures prominently in the experience of older people, and this is likely to be true for some years to come. Actually, at advanced age functional impairment may be so overpowering as to constitute an illness even in the absence of demonstrable pathology associated with specific diseases.

Ailments of older people have characteristics which influence the communities' responsibilities in relation thereto. Their diseases and incapacities, more often than not, are chronic in character. Even a high proportion of short-term illnesses among elderly people are in reality acute episodes of a continuing condition. Because of all the foregoing considerations it is especially important that traumatic injuries and short-term illnesses arising from other causes receive prompt and adequate care; otherwise, mortality rates become excessively high, recovery is impeded,

and underlying pathology may be aggravated correspondingly. Care of illness, especially when prolonged, may be a source of great economic difficulty for the individual. Not only are the costs and losses occasioned by prolonged illness great but many older persons have only limited means to meet them since they either have withdrawn from gainful employment altogether or have experienced substantial reduction in remuneration. Even for those still in the labor force, the problem of meeting costs is onerous, since long-term illnesses are either excluded altogether or receive only limited benefits under most sickness insurance schemes. This is what one might expect, since full coverage for all such conditions has not proved practicable on an actuarial basis. The only recourse under insurance is heavy subsidization from sources outside the membership. For all practical purposes, therefore, very few older persons may be expected to possess sufficient resources for satisfying their ordinary needs while meeting the added costs of expensive illness, regardless of the payment method that may be used. Community or other public agencies, therefore, must expect to supplement private effort if any reasonable level of health service is to be provided for older people, and especially when the illness is of long duration and marked by significant disability.

Hospital facilities required for treating acute illness in older people are essentially the same as those required in the case of acute illness among younger persons. To a great extent this principle is applicable to chronic illness. Hospitals for the treatment of isolated chronic diseases are passing out of vogue; instead suitable accommodations are being provided within general hospitals or in special units attached thereto. The trend now is toward shortening the period of hospital occupancy and continuing care through

the physician's office or on an outpatient basis. If the patient is not ambulant, service is extended to the home. The success of such a program depends in greatest measure on a well-organized community nursing service. In the urban centers this function, traditionally, has been the one for visiting nurse associations. A number of communities, especially smaller towns and rural areas, provide this service through the health department. Even in large cities there is a growing tendency for nursing services under official auspices to include bedside care.

I shall not go into the question of custodial care, since at most, health service is only incidental, while satisfying the daily living requirements of the person is paramount. Instead, it seems more in keeping with the title of this paper to utilize the remaining space on rehabilitation and agency relationships.

REHABILITATION

Starting with a purpose of fitting disabled persons for reemployment, rehabilitation is now being developed also as a means of maintaining function. Both of these approaches are sorely needed in most communities when dealing with the aging population. There are, of course, individuals who have acquired a physical disability of an obvious character and who qualify under ordinary rule-

... to a specific date or incident. They are merely experiencing the onset of infirmities and impairments attributable to advancing years. Their physical and mental resources need to be husbanded; their general metabolism should be improved; they need to acquire new skills and a fresh outlook on life.

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child health in this country over the past half century. Before its monumental accomplishments we stand in awe even today. But there are many reasons why still greater progress should be made during the next half century in achieving health for our senior citizens. Interest in health is greater than it was in the year 1900. Medical science is in a better position to move forward. And at least a framework of health organization now exists throughout most of this country. What this nascent program needs most to hasten its orderly development in each community is a strong citizens' group which understands the total problem confronting older people. And within the group there should be individuals who take special interest, whose concern it is to see that specific services for older people develop within a well-rounded health program for the whole community.

The efforts of an enlightened citizenry, combined with the growth and expansion of local health services, can mean a new era of health for our senior citizens. Then, indeed, can the goal of living through the later years gain new meaning and purpose

Rehabilitation programs or, better yet, programs for maintenance of functional capacity, illustrate the need for co-ordination of all community resources which can be marshaled for this purpose. Quite adequate resources may be found in both official and voluntary agencies that represent health, education, recreation, and welfare, and among private enterprises that furnish opportunities for employment. Often these are not utilized for want of an activating agency. With a well-organized local health department in operation, such a situation should not arise..

Certainly, something more in the way of physical facilities than now exist in most communities will be necessary if these and related services are to reach the full measure of their potentialities. The more thoughtful observers believe that separate facilities for the aging should not be developed except to satisfy particular purposes. Instead, standard facilities such as schools, playgrounds, hospitals, health centers, and the like should be expanded and, where necessary, altered to meet additional requirements of older people.

CONCLUSION

Professional workers in gerontology and others with related interests throughout the land are gratified, I am sure, to note the growing popular concern over hitherto neglected problems of the aging. It would seem that at long last a new public health program, which might be dubbed "hygiene of aging," is struggling to be born.

We are witnessing what, in many respects, is the counterpart of the child health movement, which began to take definite form at the turn of this century. Those who are interested in promoting health programs for older people might very well study the history of the movement for

CONTROL OF DEGENERATIVE DISEASE

BY WILLIAM B. KOUNTZ

William B. Kountz, M D., is assistant professor of clinical medicine and director of clinical research of the Division of Gerontology in Washington University School of Medicine. He is past president of the American Society for the Study of Arteriosclerosis and a former member of the Board of Directors of the American Heart Association Dr. Kountz was a member of the five-man American delegation to the First International Congress on Gerontology held at Liège, Belgium, in July, 1950. Among his large number of published articles and scientific papers are "Management of Nephritis in the Elderly," "Factors of Recognition and Treatment of Early Degenerative Heart Disease," and "Studies on the Early Recognition of Myocardial Disease by Use of the Vibrocardiogram."

THE KNOWLEDGE of the control of chronic disease is information most sought after by medical research workers in our generation. This is made necessary by the gradual increase in the age of the population. This increase in age has resulted in an abundance of chronic disease, and, necessarily, has forced physicians into this field of medicine. The shift of the population to an increase in old people and a relative decrease in younger ones is due to a longer life span produced by better understanding and control of acute disease at a younger age.

SOCIAL CARE OF THE CHRONICALLY ILL

The problem of control of chronic disease has always been with us. Formerly, it has been side-stepped by physicians,

in St. Louis and the Division of Gerontology of the Washington University Medical School, that we have every reason to believe that chronic disease, to a great extent, is reversible, and that many individuals may be benefited by the proper knowledge and proper application of medicine.

TYPES OF CHRONIC DISEASE

I should like to go a step further and point out some of the general knowledge that has been accumulated, which will clear our line of thought concerning chronic disease. Chronic disease may be divided into two types depending upon the etiological factors that have caused them. Generally, they can be divided into endogenous and exogenous causes. Exogenous disease may be defined as chronic disease arising from exposure such as that which occurs in one's environment or occupation. The endogenous type may be defined as disease resulting from wear and tear and diminished function of the body tissues. The exogenous type of chronic disease is disappearing, especially since we have a better understanding and control of such factors as infection, environmental condition, and etiological causes. The endogenous disease, with which this paper is concerned, is generally on the increase.

From the statistics of 1937 we find that 20 per cent of the population between the ages of forty and fifty have chronic diseases. This means that chronic disease is greatest at this age Likewise, in the population between the ages of twenty to seventy-five chronic invalidism and disablement are at their peak from fifty-five to sixty-five. To impress ourselves further with adequate information one notes that from 1912 to 1936 the rate of first admissions into state mental hospitals per 10,000 population over forty years of age increased from 7.7 to 49. From the statistics of the

and the control by society has been to place individuals in infirmaries and almshouses. This has been primarily because the individuals have not been wanted in the homes. Such social treatment has proved very unsatisfactory, particularly with the great increase in the number of older people. It has *now become a problem to prevent the* accumulation of a great number in institutions. The social care has broadened, and attempts have been made to maintain these individuals in their homes by giving them outside medical care as well as direct social, recreational, and educational care. Also, there has been some erection of proper buildings where two families may live adjacently but not together. Villages have been designed in which older people can get along without too much work. The economic adjustment which is frequently necessary in older people has received attention by the use of old age pensions and insurance benefits of different types.

The increase in the numbers of the aged has developed many problems, and society is beginning to see that the only approach to chronic disease, like all other diseases, must be medical. One may justifiably say that the social aspect is a mere stopgap to give medical research a chance to catch up with the knowledge of how to prevent the changes that occur in later life.

Since I am interested in geriatrics and medical research I shall give some of the views and aims of geriatric medicine. In order to do this I should like to begin by pointing out the factors which are concerned in chronic disease. First, can anything be done about age or chronic disease? Is an individual, who is old and debilitated, somewhat like a cooked egg, the material of which is fixed and which cannot be reversed?

I can assure you from studies at the Infirmary Hospital

necessary to have only six children, provided they were normal at birth and under the care of a pediatrician. This indicates a striking improvement in child welfare.

Medical knowledge at this time as far as geriatrics is concerned, can be compared to the knowledge of pediatrics about the year 1850. Child welfare since then has been brought under control by increased knowledge of scarlet fever, smallpox, diphtheria, and the like, as well as general improvement in the nutrition of childhood. In the last few years the antibiotics have been developed which have limited infectious diseases in childhood as well as in adults and have made the world much safer for both. We all understand that what the child lacks at birth are anti-infectious processes which are biochemical phenomena that develop and protect him from disease. The artificial method of developing anti-infectious processes in childhood has superseded nature's way of having to have certain forms of disease in order to become immune. It is, therefore, necessary for us as individuals studying geriatrics to compare the gerontological problems with previously established pediatric problems. We do not have to worry about scarlet fever and infectious diseases in older people since they have developed antibodies We do have a biochemical situation in these older individuals which we might compare to measles and mumps of childhood. This biochemical phenomenon that develops in older people is the so-called exhaustion of aging, the wear and tear of time, and the exhaustion of body function. In some this change is early and in others later. It is important for us as students of gerontology to evaluate these various conditions.

CHRONIC DISEASE CAN BE CONTROLLED

The present attitude of medicine has been to look at

United States Public Health Service we find that in the chronically diseased patients in the United States nervous and mental diseases play an important part. The estimated number of individuals disabled by chronic diseases in the United States may be broken down into various types. Nervous and mental diseases lead with an estimated quarter of the total diseased population. Rheumatism has a high incidence, as has heart disease. The chronic infectious diseases such as tuberculosis have dropped to a relatively low level. The cause of death in the total population, one notes, is primarily from heart disease at a rate of 325 per 1,000. Cancer runs a close second with 150 per 1,000. Again, tuberculosis and the chronic diseases play a relatively small part as to cause of death. It is, therefore, recognized that circulatory impairment, chiefly due to arteriosclerosis, hypertension, and cardiac disorders, is the predominant factor in the pathogenesis of many of the mental and nervous disorders and in the arthropathies and heart disease itself. This emphasizes the importance of the study of heart disease in senescence in order to overcome the many forms of chronic disease.

Perhaps it would be well to review some medical history, particularly with regard to the problem of pediatrics. Physicians had difficulty with child care when its medical problems were poorly understood. In this country, in the year 1852 a family had to have twelve children in order to raise six, that is, 50 per cent died before maturity. In 1872, to raise six children, the family had to have ten. In other words, there had been some improvement in child welfare which was reflected in the death rate. In 1900, to raise six children the family had to have eight. The expectation was that a quarter of the child population would die before maturity. In 1940, in order to raise six children, it was

factors of nutrition Then, as the food goes through the body it has been shown that individuals use it poorly. Studies from the laboratory show that essential amino acids may be reduced and that this may lead to a negative nitrogen balance and a loss of protein in an attempt of the body to adjust its protein metabolism. This is probably one explanation of why individuals break and age. Proper accumulation of protein may prevent the body degeneration.

Much research is needed, particularly from a standpoint of nutrition, as to the mechanisms that go on in our bodies that bring about absorption of various food substances. Fat is poorly used by the elderly body so that there has been an attempt to link disturbed fat metabolism with arteriosclerosis Research has advanced knowledge generally, yet, in my opinion, there is a lack of specific work in many instances because of a poor approach. Because of the close relationship of medicine to surgery there has always been an anatomical evaluation of disease and not a physiological evaluation, which is so necessary in chronic disease.

The research and clinical work in cancer is an example. The knowledge of cancer has grown to many volumes, yet the knowledge of cure of cancer is practically zero, from a medical standpoint. There has been a great deal of work done in which cancer cells have been studied, but very little attention has been paid to the state of the body in which cancer grows. I should like to give a specific example. It is known that certain strains of mice injected with coal tar develop cancer. Other kinds of mice do not develop cancer when injected with this substance. Much study has been devoted to the cancer cells produced by this technique, but very little study has been made to determine the difference between the strains of mice that do develop cancer and those

degenerative disease in aging as an inevitable condition. We know better, but because of lack of knowledge many teachers assume this attitude primarily because they have no interest in older people. The geriatric viewpoint is that arteriosclerosis and degenerative diseases in general present a biological problem not unlike the problem that the pediatric branch of medicine has overcome. Specific diseases, such as diabetes and cancer, are simply manifestations of an exhaustive process which to a certain extent can be modified. It is my belief that all of these conditions, known as degenerative disease, form as a result of certain deficiencies of body function and that they can be kept at a minimum by restoration or partial restoration of such phenomena. Thus, the glands of internal secretion which have to do with our internal metabolism play an important role in the burning of food in our bodies. It has been shown that the estrogens may play an important role in the carbohydrate metabolism, as well as other substances, whereas androgens play a leading role in protein metabolism. It is well recognized that the pituitary gland and pancreas play an important role also in carbohydrate metabolism.

Perhaps we should first begin by attempting to look at a patient as a whole and not as a cardiac case nor as a specific anatomical problem. In older people there is a dulling of digestion; food taken into the mouth is usually poorly digested compared to the digestion of the younger individual. Exhaustion of enzymes as well as of hydrochloric acid, which aids in digestion, has taken place. The liver function is generally somewhat reduced. This poor digestion may mean a slower absorption of amino acids in the body and probably, in a high percentage of individuals, a flat or delayed type of glucose tolerance curve. This, in turn, means that the individuals no longer adjust to the important

THE INDUSTRIAL PHYSICIAN AND THE OLDER WORKER

BY NEWTON E. LEYDA

Newton E. Leyda, M.D., is medical director of the Moraine Products Division of the General Motors Corporation and of the McCall Corporation in Dayton, Ohio. He is a fellow of the American Association of Industrial Physicians and Surgeons, a member of the American Medical Association and of the Ohio State Medical Society, and a member and past president of the Montgomery County Medical Society. He is past chairman of the Metropolitan Health Council of Dayton's Community Chest and in that capacity has been active in planning community-wide programs dealing with preparation for retirement.

THE INDUSTRIAL physician has for centuries been striving to prolong life, conquer hazards, and repair damage to the workers in industry. In 1700 Bernardino Ramazzini, an Italian physician, wrote a book emphasizing the existence of disease connected with the hazards of occupation. Since then many books and papers have been written by the industrial physician. An outstanding example is Charles Turner's *The Effects of Arts, Trades, and Professions and all Civic States and Habits of Living on Life and Longevity.* The thesis of this hundred-year-old book was to analyze the effective relationship of labor and age upon the worker's life.

Industrial medicine and its physicians have developed highly organized programs of health conservation for the industrial worker. These programs reach beyond the worker and into his family. The United States Census for

that do not develop cancer. It would therefore seem that the study of the physiology of the body in degenerative disease is of most importance. This brings us to the point of why this viewpoint exists in medicine. We can readily understand the trouble when we consider the fact that medicine has always looked at anatomy and become so focused on anatomical change that it loses sight of the physiological change. It is wise then to study not only the disease but the body in which disease grows. Farmers know that in growing a crop two factors are to be considered. Of these, the soil is as important as the seed. It is our opinion in gerontology that too little attention has been paid to body physiology and too much to the anatomical change. It is assumed that the elderly body is the same as the young, but it is not. Therefore, in order to understand the human body and diseases associated with it, one must forget the anatomical and look to the physiological process in which the disease grows.

SUMMARY

Proper control of chronic disease is not unlike the control of disease of any other type. It must be through medicine. The social and economic aspects are mere stopgaps to enable medicine to understand many of the degenerative processes to which too little attention has been paid by medicine in general. It is our belief that it is highly probable that healthy men of one hundred years will be just as capable of maintaining their economic and social status as healthy men of forty, and we believe that it is feasible and highly probable that in the next generation older people will maintain their health.

RETIREMENT

In the two industrial plants where I have the pleasure of serving as medical director, I have seen a number of workers joining the twenty, twenty-five, and thirty-year clubs. There are over fifty employees over sixty-five working because they want to work. They are physically and mentally capable of working. They emphatically state that they have no intention of retiring as long as they are capable of doing a regular day's work. They have thought of retirement and some have plans after retirement, but to most of them retirement means inactivity, and inactivity hastens death. Hard work is not a factor of age, but worry is. If one has the ambition and incentive to work he should be permitted to do so. Pension plans are fine, but the medical director of the industrial plant should be permitted to say when the individual is ready for retirement. An industrial plant has a complete record of the worker's skill, aptitude, and attendance. The medical department has a record of the physical and mental condition of the worker. These two records should be combined in evaluating the worker's ability to continue work.

Mr. C. E. Wilson, president of General Motors Corporation, in his speech printed in the June, 1950, issue of the *GM Folks*, which explains the five-year agreement with the UAW, said: "Normal retirement age will be sixty-five but an employee at his own option, provided he is capable of doing his job, may continue to work until the automatic retirement age of sixty-eight. At the option of the Corporation, an employee with unusual skill and good health may continue beyond the age of sixty-eight." This is a great step forward in the relationship to the older worker.

It is illogical to retire a person because he reaches the age of sixty-five when he is doing a good job, but is a little

1900 showed that there were only three million people in the age group of sixty-five and over. Most of these were employed. Today there are over eleven million in this age group. Less than 25 per cent of these have jobs. This increase in the number of people over sixty-five can be directly traced to the remarkable advances made in medical science in all its phases in the past fifty years. As time goes on, more rapid discoveries in ways to cure and to conquer diseases and more exact means of detecting and diagnosing physical impairments and diseases in their early stages will be released to the public.

Longevity has increased more than 35 per cent in the last half century, making the life expectancy between sixty-eight and seventy. The medical knowledge that is available now and is so rapidly developing, will soon raise the age expectancy to seventy-five. It is obvious that new standards in evaluating the ages are necessary. The voting age of twenty-one should be lowered; the productive decline at forty should be raised; and certainly the retirement age of sixty-five is not right. One's age is a combination of psychological, genetic, and biological factors.

One of my most pleasant customs for the past several years is taking a patient of mine to church on Easter Sunday. She was born in March, 1857. Last Easter as we were driving downtown to the church, she was apologizing for not having a new Easter dress. She had planned to have one. About a week before Easter the clerk at the dress shop called to say that she had a dress that was "just right for her." Mrs. Brown went to the store and took one look at the dress and said, "That dress looks like it was made for a woman ninety-four years old, and I am only ninety-three." She did not buy the dress. It is obvious that today we find fewer people old at the age of sixty-five.

talk to twenty or not more than thirty minutes. This allowed time for a question period afterward.

About two hundred persons attended these meetings, and the general desire expressed on a questionnaire was to repeat the institute meetings next winter and to explore other fields, such as religion, farming, soil conservation, new trades, co-operative work and marketing, and to have more discussions on medical care. These meetings proved one thing to the committee. They can be carried on as a community project more successfully and with a better fellowship than by industry alone.

The first concern of the worker should be his physical and mental health. A good rule is that on one's birthday each year after forty, one should have a complete physical examination. A written report from the examiner on the findings in the examination and recommendations to guide one for the coming year would result in better health.

The subject of illness and disabilities of the aged is a challenge to the medical profession. The subject of retirement of the older worker is a challenge to the entire community. The older worker who first learns how to maintain his health and ages understandingly will go on working. If he keeps his hands busy and his mind alert he will not have time to grow old mentally.

In conclusion, the industrial physician, with his special training, should examine the older worker and determine his physical and mental fitness to continue on the job, have his job changed, have limited hours of work, or be placed on the list for retirement. There is a wealth of skill and mature knowledge in an older worker. He should have the privilege of using it as long as he is physically and mentally fit. In this way he maintains his independence and self-respect and is a good citizen If retirement is inevitable,

slower than he used to be. This worker's ability and knowledge of his job could be utilized to good advantage by shortening his work day to six hours instead of eight. His vacation time should be increased each year in preparation for his retirement. During this tapering-off period another worker could have the advantage of the training offered by the older worker. He would be ready to take over efficiently when the older worker is ready to retire.

CO-ORDINATION OF INDUSTRIAL AND COMMUNITY PROGRAMS

Conditioning for retirement cannot be an elaborate national plan. To be successful it should be a local community plan in relation to the local industries. Planning for leisure time at retirement should be a project for every community. An over-all program by the combined efforts of industry, local agencies, local government, and the medical society should be established. Many say that this is the responsibility of industry, especially the personnel and medical departments. It is obvious that this method is too limited, because when the worker retires he becomes more a part of the community than the limited part of the industry from which he has become dissociated.

Last winter, in Dayton, through the combined efforts of the *Industrial Personnel Association, the Metropolitan* Health Council (a division of the Community Welfare Council of the Community Chest), and the County Medical Society an institute for the aged was conducted. Four meetings were held a week apart. Speakers were secured to talk on health, social security, wills, insurance, nutrition, hobbies, art, recreations, and family life. Two or three subjects were covered each session. Each speaker limited his

talk to twenty or not more than thirty minutes. This allowed time for a question period afterward

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training periods in institutes for the aged should be made available through a community group.

A worker who was preparing for retirement wrote these lines:

Of course, government bonds out of each pay,
They'll stand you well for a rainy day.
If you use your head, make things of wood –
Buy tools now, but buy them good.
So when you retire, get ready for joy,
Forget you're a man, pretend you're a boy.

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PHYSICAL RESTORATION AND THE OLDER PERSON

BY MICHAEL M. DACSO

Michael M. Dacso, M.D., is director of the Department of Physical Medicine and Rehabilitation at Goldwater Memorial Hospital in New York City and assistant clinical professor of Bellevue Medical Center. He was a member of the Planning Committee for the Education Section of the National Conference on Aging held in Washington, D.C., in August 1950. His memberships include the American Rheumatism Association, International League Against Rheumatism, and the American Congress of Physical Medicine His published works have been primarily in the field of rheumatoid arthritis.

THE TREMENDOUS improvement and new discoveries in medical science in the last two or three decades have extended the life span of man to heretofore unexpected length. It is well known that, at the turn of the century, only 4.1 per cent of the total population of this country was sixty-five years of age or over. In contrast to this the Bureau of Census estimates that this figure will rise in 1950 to about 7.7 per cent and in the year 2000 it will reach the remarkable height of 13.3 per cent. These figures show a surprisingly close agreement in all civilized countries. In countries in which medical and public health facilities are not well developed, the average life expectancy is naturally much lower. The life span of a native in certain parts of Africa is still twenty-seven years, the same as that of a citizen of ancient Greece.

Medical science is to a great extent responsible for the extension of the life expectancy of man. The increase in average longevity has created what we can safely call one of the most important public health problems of our time, namely, the medical and social management of an aging population. If this trend continues and if we fail to plan constructively for the care of the aged, the ratio of the chronically ill old people to their healthy young supporters will change in a manner not compatible with sound public health and economic principles. Medical science, responsible for adding years to life, now faces the responsibility of *adding life to these years.*

It must be admitted that these problems of aging have caught the medical profession somewhat off-guard, and only in the last few years has there been any noteworthy interest shown in geriatrics, the medical art concerned with the ailments of the aged.

CHRONIC DISEASE AND PHYSIOLOGICAL AGING

According to the data of the last available National Health Survey, chronic disease or gross physical impairment was present in about 58 per cent of all persons sixty-five years of age and over. This and much other statistical evidence show how closely the problems of the aged and those of the chronically ill are related to each other. In spite of this close relationship it is not to be understood that diseases of the aged and chronic illnesses are synonymous. Many of the problems in these two disease groups are so related that a closer co-operation between study groups concerned with them would be of great advantage.

It is of practical import to classify the morbid conditions occurring in the aged into two main groups: Group I —

diseases not characteristic of senescence but far more frequently seen among the aged than in the younger age group; Group II — diseases which are direct results of the physiological aging of the tissue.

Carlson, in his study, listed the following nine causes of physiological aging:

1. *Gradual tissue desiccation.* By determining the electrolyte concentrations in the tissue cells some doubt has been raised as to the reliability of the older experiments which seem to establish a gradual tissue desiccation as part of the aging process.

2. Gradual retardation of cell division, capacity of cell growth, and tissue repair, including reduced capacity to produce immune bodies in case of infections.

3. Gradual retardation in the rate of tissue oxidation (lowering of the basal metabolic rate).

4. Cellular atrophy, degeneration, increased cell pigmentation, and fatty infiltration.

5. Gradual decrease in tissue elasticity, and degenerative changes in the elastic connective tissue.

6. Decreased speed, strength, and endurance of skeletal neuromuscular reactions.

7. Decreased strength of skeletal muscle.

8. Progressive degeneration and atrophy of the nervous system [illegible]

[illegible]

for the cells a [illegible]
weakening of [illegible] links in the complex process of homeostasis will produce deterioration.

In clinical practice this classification is a good, concise, and useful tabulation of the causes of physiological aging. The first group, consisting of the commonly encountered chronic diseases, has received much more attention in the past than has the second group.

For some reason the conditions caused by physiological aging have been accepted as inevitable development and

not much has been done to avert them. It is true that medical science still cannot offer much to correct these degenerative changes, but there is much that can be done to adjust the aged patient to the gradual changes and make his life happy and relatively free of suffering in spite of approaching senescence. Actually, it is in the early phase of aging that the physician can achieve the utmost in the restoration of certain regressing functions. Emphasis should be placed on early introduction of these techniques. It is presently felt that "preventive geriatrics" is a good term for treatments and techniques which aim at the early elimination of disturbing clinical symptoms caused by the advancement of years. It is to be hoped that this important phase of geriatrics will receive more attention in the future. It is not my intention to become technical about methods applied in the restoration of physical fitness in the aged. I shall only briefly touch on the principles of these activities.

PRINCIPLES AND TECHNIQUES OF PHYSICAL RESTORATION

Whenever we speak of "restoration of the aged to greater fitness or normal health" it must be remembered that the terms "health" and "fitness" are only vaguely defined and subject to individual and environmental variations and influences. Probably the most important question to be answered is "who is fit for what." An elderly person who probably would fail in performing some of the most strenuous fitness tests may still be a good candidate for many other activities requiring less physical effort.

Neuromuscular function. In training these older patients, it is important to remember that their endurance is even more impaired than their actual muscle strength. This implies that the physical restoration activities should

be directed toward the increase of both the strength and endurance of the musculature. Elimination of neuromuscular inco-ordination is also a major step toward greater physical fitness. It is a serious mistake to train the elderly patient with an unrealistic goal in mind. The guiding principle in the rehabilitation of elderly individuals is to get the most out of them without jeopardizing their general health.

Endocrine function. In addition to the neuromuscular function the status of the endocrine system should also be known, for it plays a considerable part in physical fitness. In recent experiments the administration of methyltestosterone to man in the higher age group has produced both subjective and objective improvement in certain aspects of physical fitness. The prolonged administration of these hormones is not entirely without danger. Amphetamine and its different derivatives have been very often suggested to combat the physical fatigue and mental depression so often seen in the aged. Undoubtedly, these drugs have a certain beneficial effect on the aforementioned symptoms, but the possibility of overstimulation should not be forgotten Arnett and Harris, in their survey on the subject, quoted a patient as saying that after taking the drug she had "more energy but not enough strength to back it up." In the layman's language this is the best description of the dangers inherent in the prolonged use of such drugs It is inadvisable to use drugs merely to improve a patient's physical fitness. They are only to be used for certain specific diseases and under strictest medical supervision.

Exercise. A much better and more physiological way to maintain or restore an elderly patient's physical fitness is to prescribe a regime of graduated exercises and keep him as active as his strength and endurance permit. Parallel

with the improvement of general physical condition, mental depression may also clear up. Very often the depression is just an expression of the patient's frustration, a direct result of his limited ability to cope with the simple physical demands of daily life. Obviously, nature sets a limit upon all attempts to keep the elderly patient healthy. Sooner or later a major illness will be manifested and, in spite of the efforts expended, it will terminate fatally.

Vascular disease. It is the degeneration of the cardiovascular system which plays the most predominant role in the diseases of the aged. Arteriosclerotic changes will eventually result in impaired nutrition of the tissues and thereby cause disturbing clinical symptoms. The severity of such diseases cannot be prognosticated. Arteriosclerosis in the lower extremities may only cause tiredness or slight pain on strenuous walking, but it can also produce gangrene resulting in loss of the limb. Since the ultimate outcome of a circulatory disturbance cannot be predicted, it is of utmost importance to take particular care of even the slightest incipient symptoms. Fortunately, there are good medical, surgical, and physical means of stimulating impaired peripheral circulation.

In the management of peripheral vascular diseases, physical medicine offers a large variety of treatments. On a carefully prescribed and executed program consisting of special exercises, whirlpool, massage, intermittent venous occlusion, and skillfully applied reflex heat, these patients show marked improvement. It is well to remember that the application of direct heat to poorly vascularized areas should be avoided whenever possible. Impaired circulation cannot cope with the suddenly increased tissue metabolism and an abrupt aggravation of the local condition may follow.

Persistent foot hygiene, especially in the diabetic patient, is very important. The loss of many limbs could have been averted by better care of patients' feet.

The dreaded arteriosclerotic involvement of the coronary arteries rates prominently among the causes of morbidity and mortality in the aged.

Hemorrhage or occlusion of the middle cerebral artery resulting in hemiplegia is another frequent arteriosclerotic complication. Presently, there are about one million people in this country, most of them aged persons, who are afflicted with hemiplegia. It is fortunate that methods to rehabilitate such patients have been so well developed that today the hemiplegic can anticipate a much shorter hospitalization period and far better functional return. A majority of hemiplegics can return to their previous jobs or some other gainful employment after suitable rehabilitation training.

Musculoskeletal degeneration. The involvement of the musculoskeletal system with approaching old age is even more conspicuous than that of the vascular system. The layman uses the condition of the musculoskeletal system as a yardstick in estimating a person's age. The gradual wasting of the general musculature is one of the most constant outside manifestations of aging. This wasting is histopathologically well characterized as "brown degeneration" and fibrous tissue replacement. There is nothing that medical science can offer as yet to reverse this degenerative process. There is another equally, if not more important, reason for this wasting of muscles in the aged: the atrophy caused by complete or partial inactivity. Since this is a man-made condition there is a great deal we can do about it. The false concept that an elderly person has to rest as much as possible and should refrain from physical activity to protect his heart is an

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tures of the hip, are among the leading and most dangerous complications of later years. Today, when orthopedic operations, such as the different internal fixation methods, have reached a remarkable degree of perfection, the prognosis of these cases is considerably better than a few years ago. With improved surgical technique there is still a high percentage of nonunion observed. Even in the "lost cases" proper bracing, intensive gait training, and general conditioning can restore a fairly good function and ensure an ambulatory existence. Regardless, however, of the expected healing tendency it is imperative that muscle setting and general bed exercises be started from the first day after surgery unless severe pain prevents such a program.

Symptomatic coughing. Another condition prevalent in the older age group is a chronic, productive cough. If an incipient heart failure is responsible for the cough, proper digitalization, diuretics, and suitable diet may relieve the symptoms. Sometimes an insignificant cough is the first sign of malignant pulmonary tumor. Careful physical examination and periodic checkups can detect malignant changes early enough for successful surgical removal. Contrary to former beliefs pulmonary tuberculosis is not rare in the higher age group. After the elimination of all serious pulmonary diseases there will still be a sizable group remaining in whom even the most painstaking clinical study cannot demonstrate any organic changes, yet the cough persists These cases are often diagnosed as "chronic bronchitis of the aged" or "senile emphysema." This condition is presumably a result of degeneration of the pulmonary elastic tissue together with changes in the thoracic cage leading to an inadequate ventilation of the lungs. In the treatment of this group specially designed abdominal belts, the practice of postural drainage, breathing exercises,

obsolete and dangerous dogma. It has been satisfactorily proved by various investigators that the injudicious use of rest may cause more harm than good. The pronounced decalcification of the resting bone is good evidence of the altered mineral metabolism. All ill effects caused by enforced unnecessary rest can be efficiently combated by a well-planned regime of exercises. Changes caused by prolonged inactivity are not only limited to the muscles, bones, and joints, but often affect almost every system in the body.

Arthritic disease. Diseases frequent among the aged are the different types of arthritides. With the exception of a few cases of late rheumatoid arthritis and gout the overwhelming majority of joint complaints are the result of osteoarthritis. Osteoarthritis of the hip joint, as its name, *malum coxae senilis,* signifies, is almost without exception a disease of the aged. Involvement of the spinal column can be the source of excruciating pain and eventually lead to deformity.

The recently discovered drugs, such as ACTH and cortisone, give reasonable hope that a cure for rheumatoid arthritis is at least within sight. Unfortunately, there is no specific treatment available for osteoarthritis of the aged person at this time. Physical medicine and suitable rehabilitation methods can, in most of the cases, relieve the patient's pain and restore motion in the afflicted joints. The rule here, again, is early and persistent treatment. It should always be remembered that chronic diseases require "chronic" treatment. The treatment of an osteoarthritic should be continued until the patient becomes free of pain and good function has been attained. Even beyond that point a regular regime will have to be maintained to preserve the therapeutic result.

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and conventional medical measures have proved to be successful.

A discussion of the genitourinary diseases whose incidence is high in the elderly male group is unnecessary in this presentation, since their correction is primarily the concern of the genitourinary specialist. A discussion of a large number of chronic diseases of the aged has been omitted. Emphasis has been placed on those conditions which can benefit from a physical rehabilitation program.

Nutrition. A discussion of physical restoration of the aged would be incomplete without brief mention of dietary factors. It is essential to emphasize that there is no specific diet for the healthy aged. The cause of nutritional deficiency in an otherwise healthy elderly person lies more in poor eating habits than in the quantitative composition of his meals. Sometimes, however, impaired utilization may cause nutritional deficiency despite a normal quantitative food intake. Not only the lay public but even some physicians who are not familiar with the special demands of the elderly seem to believe that when a person reaches a certain age it is advisable to put him on a "light diet." This "light diet" is seldom specified and often leads to unhealthy dietary habits. It is usually rich in carbohydrates, may contain sufficient fat, but as a rule is very limited in its protein content. This type of diet may lead to a negative nitrogen balance with all of its serious consequences.

A well-balanced diet becomes extremely important if either conditioning or therapeutic exercises are prescribed and practiced. The energy required to perform simple exercises is often startling. Energy expended in stair climbing is about fifteen times as much as that required walking the same distance at the rate of two to two and one-half miles an hour. The increased energy demand imposed on a

patient by exercises must be met by equal intake of energy in the form of different food materials. If this additional demand is not met a depletion of body tissues ensues, materially impairing the fitness of the individual. Practically speaking, this means that an increased energy consumption without adding extra energy to the diet actually deconditions the patient instead of conditioning him.

In addition to the basic food elements—proteins, fats, and carbohydrates—an adequate supply of vitamins and minerals has to be added to the diet. A complete or partial avitaminosis or insufficient amount of minerals, such as calcium, phosphorus, and iron may cause clinical signs and symptoms, even if the intake of the basic food element is satisfactory.

RESTORATION OF ACTIVITIES OF DAILY LIVING

A major but heretofore rather neglected aspect of rehabilitation of the elderly age group is the testing and training of the activities of daily living (A.D.L). This is a careful compilation of activities essential to a self-sufficient life. The importance of A.D.L. training has been repeatedly emphasized by Rusk and his co-workers. Deaver's manual is one of the most useful aids in this phase of training.

The chart used in our department lists more than a hundred self-care, locomotion, traveling, and hand activities *indispensable* to everyday living:

A Bed Activities
   1 Rolling to right and then left side
   2 Sitting erect in bed
   3 Moving forward and backward in sitting position
   4 Turning body and placing legs over side of bed
B Toilet Activities
   1. Motion of combing or brushing hair

2. Motion of brushing teeth
3. Motion of shaving or applying make-up
4. Motion of washing hands
5. Motion of washing face
6. Motion of washing body
7. Motion of washing extremities
8. Motion of removing dentures
9. Motion of washing dentures
10. Motion of caring for finger nails
11. Motion of maintaining and bedpan

C. Eating and Drinking Activities
1. Motion of cutting meat
2. Motion of buttering bread
3. Motion of eating with a fork
4. Motion of drinking out of a glass
5. Motion of drinking out of a cup
6. Motion of stirring coffee
7. Motion of drinking with a straw

D. Dressing and Undressing Activities
1. Putting on undershirt
2. Putting on shirt
3. Putting on trousers
4. Tying tie
5. Putting on socks
6. Putting on shoes
7. Putting on brassiere
8. Putting on underpants
9. Putting on girdle
10. Putting on dress
11. Putting on stockings
12. Putting on coat
13. Putting on hat
14. Putting on gloves
15. Putting on eyeglasses
16. Putting on braces

E. Hand Activities
1. Write name and address
2. Fold letter, place in envelope, and seal envelope

3. Open envelope, remove letter
4. Open and close safety pin
5. Use dial telephone
6. Turn pages of book
7. Wind wrist watch
8. Strike match
9. Manipulation of
   a) Buttons
   b) zippers
   c) snaps
   d) hooks and eyes
   e) laces
   f) bows
   g) ties
   h) buckles

F. Wheelchair Activities
1. Bed to wheelchair
2. Wheelchair to bed
3. Managing brakes
4. Raising and lowering foot rests
5. Propelling wheelchair backward 30 feet and stopping
6. Propelling wheelchair forward 30 feet and stopping
7. Opening and closing door in wheelchair
8. Wheelchair to chair
9. Chair to wheelchair
10. Washing at sink
11. Wheelchair to toilet
12. Toilet to wheelchair
13. Wheelchair to bathtub
14. Bathtub to wheelchair
15. Wheelchair to automobile
16. Automobile to wheelchair
17. Wheelchair to floor
18. Floor to wheelchair

G. Elevation Activities
1. Bed to erect position
2. Erect position to bed
3. Wheelchair to erect position

4. Erect position to wheelchair
5. Chair to erect position
6. Erect position to chair
7. Erect position to toilet
8. Toilet to erect position
9. Erect position to tub
10. Tub to erect position
11. Down to floor
12. *Up from floor*
13. Pick object from floor

H. Special Hand Activities
1. Open and close cylinder lock
2. Open and close icebox door
3. Open and close drawers
4. Open and close doorlock with key
5. Open and close door hook
6. Open and close window
7. Pull window shade
8. Work switch
9. Work plug switch
10. Work push button or bell
11. Work pull chain light
12. Open and close cabinet lock
13. Turn 4-pronged faucet
14. Turn circular faucet
15. Open and close medicine bottle
16. Open and close bottle

I. Walking and Climbing Activities
1. Walking forward 30 feet
2. Walking backward 10 feet
3. Walking sideward 10 feet
4. Opening door, walking through, and returning
5. Up 15 degree ramp, 3 feet
6. Down 15 degree ramp, 3 feet
7. Up one flight of stairs, one hand rail
8. Down one flight of stairs, one hand rail
9. Up standard curb
10. Down standard curb

11. Up bus steps
12. Down bus steps

J Traveling Activities
1. Cross standard street on green light
2. Get in bus, place coin in turnstile
3. Go through turnstile and stand holding on overhead strap
4. Sit down and get up from bus seat
5. Travel to middle door of bus
6. Descend from bus to street
7. Walk to taxi, 10 feet, open door and enter cab
8. Descend from cab, close door and walk 10 feet
9. Walk forward 300 feet with package
10. Carry cafeteria tray with dishes

Upon admission each patient is carefully tested and if the activity can be performed a block in the corresponding line of the A.D.L. chart is filled in with black pencil, if not, it is left blank. During the course of treatment the patient learns to perform these activities in which he failed. When success is reached, the corresponding block on the chart is filled in with red pencil and the date noted. If the red and black blocks form a solid column the patient can be considered totally rehabilitated. Naturally, 100 per cent rehabilitation cannot always be achieved. If we consider, however, that in performance of daily duties we use much less than 100 per cent of our physical ability, it will be clear than even a 60 per cent improvement can be considered very successful. This achievement may change the elderly patient's attitudes and potentialities.

The restoration of these activities requires a great deal of skill and patience. Many of the seemingly simple activities, such as tying shoelace, lifting spoon, and drinking, have to be reduced to several phases. Each phase is then taught separately until the patient can join all of these

individually learned phases into a single purposeful co-ordinated motion. In many of these activities the time element is also important, and this has to be noted on the records. We consider a well-executed A.D.L. program a necessary prerequisite for a successful functional rehabilitation.

CONCLUSION

In this outline some principles pertaining to the physical restoration of the aged have been discussed. It is obvious that successful physical rehabilitation requires complete co-operation of a team consisting of physical therapists, occupational therapists, social service workers, psychologists, vocational counselors, and speech therapists as well as physicians. It is our hope that a closer co-operation between the physician and other professional services will eventually result in further improvement in the medico-social management of the aged.

RESPONSIBILITY OF EDUCATION TO THE OLDER ADULT

BY THOMAS A. VAN SANT

Thomas A. Van Sant, B.S., is president of the Department of Adult Education of the National Education Association, a member of the executive committee of that Association, and director of adult education of the Baltimore, Maryland, city schools. He is also president of Baltimore's Adult Activities Council. He has been very active in adult education and extension work, and during the summer of 1950 was a delegate to the International Seminar on Adult Education held in Salzburg, Austria.

OLD AND middle-aged people do not have problems of employment, recognition, independence, security, and isolation because they are uneducated, stupid, or inept. They have these problems because of physiological changes and the culture in which they live. This culture is based, in part, on mortality experiences and on physiological stereotypes that are no longer tenable. The cumbersome weight of endless thousands of years of thinking and acting, however, is not easily shifted by changed conditions of the last few decades. It is not surprising, therefore, to realize that existing culture continues, willy-nilly, to push people in the older years, and many in the middle years of life, into varying degrees of economic and social discard. Education, then, by the very nature of this complex problem cannot hope to help older-aged groups materially by being concerned with their education alone.

Genius or dullard, handicapped or veritable dynamo of

energy, any middle- or older-aged person may feel the weight of traditions, customs, and even prejudices that discriminate against him. Scarcity of employment opportunities for those in the middle or older years who seek work, the establishment of compulsory retirement ages regardless of conditions or abilities, and subtle attitude changes in the home, in the club, or in the neighborhood are clear and ever-present evidences that our modern culture is not adjusted to the realities, the best interests, or fundamental needs of people once they have reached or passed middle age. Teaching people hobbies so that they can more easily accept being discarded, or teaching those in later years new vocational skills when their basic problem does not concern their vocational competency is being less than realistic.

Historically, our culture has been adjusted to the interests, the abilities, and the needs of children, youth, and young adults. The reasons are not too difficult to find. In past years not enough people survived to middle and old age to make a place for themselves in the currents of the developing culture. It has been within the last hundred years that life expectancy has been pushed dramatically and significantly into the uncharted later years. The size of the problem alone, with ten million men and women over sixty-five in our country's population, presents an imperative for intelligent action. Yet, in spite of swollen proportions, no ready and easy answers have developed. Not only is our culture unprepared for unprecedented numbers of middle and older-aged people, but it is disconcerted, shocked, and amazed to realize that the time-honored and hallowed concepts of doddering old age are being blown wide open by the vigorous, active, demanding men and women who dislike intensely being buried beneath such

babble. Quite patently, modern institutions and services—and education among the foremost of them—are out of gear with the actualities of middle and old age.

Norms which are accepted for the general population are often not seen as applicable to the middle and later years of life. The fact that people in the older years are no longer a rarity and that most of them are not fragile or debilitated may be an obvious fact, but we still do not know how to fit them into those norms which are held true for mankind in general. It is almost as if we say to ourselves, "Yes, these norms are true for life, but of course not true for old folks." Even the accumulating evidence that older people are driven by most of the same desires activating everyone else has had a hard time finding a foothold in our thinking. It is not strange, therefore, that education has been slow to recognize the needs of the older ages, slower in attempting to do anything about the needs, and far from successful in bringing to bear upon the problems the grand value of its resources, or the full help that is present within its techniques of organization, analysis, study, instruction, or training.

If it is to their interest and advantage, older people can learn quickly, thoroughly, and well those things they want to learn, just so long as the learning situations are not inconsistent with physical, mental, and emotional capacities. Age does not make dull people brighter, although it may help to make both the bright and the dull more acceptable. Within the bounds of native abilities and whatever handicaps may exist, a person of any age can learn new skills, gain increased information, develop new insights, and change some attitude as a result of educational programs. The implications of this fact for older people are just now beginning to be exploited on an extensive basis Patently, too, the

education designed for the older-aged groups needs extremely careful individual adjustment if it is to be worth while. It is even more important, however, for those in charge of the educational program, and for those being educated to know where they are going and why they are going. Education for the sake of a respectable activity may have its place in an effete society, but it is hard to justify in a world filled with the potentialities of so many fruitful avenues of study.

Unfortunately, compartmentalized concepts of old age have led into a whirlwind of poorly conceived and often barren activities. Impelled by a growing recognition of the sheer size of the older-aged group, and caught in a sentimental stereotype of the "dear old folks," many "educational" programs in order to get started have bordered on the edge of second-and third-class entertainment. "Golden Age Clubs," "The Silver Top Fraternity," and "Groupings for the Mellow Years" are typical of the labels pasted on some of the best and some of the lesser activities of this sort. Sentimental appeal oozes from them, and they fall easy prey to the human interest angle of modern journalism. Within short months the popularity of such appeals draws many easy converts. Yet we know that, desirable and sweet as such actions may be, the resources, man power, and know-how of education are needed elsewhere. There is the danger throughout all this, in a sense opiates for the aged, that popular acclaim may lead to numerical success, and nothing proves success quite so much to educators as large enrollments.

NEED FOR DEFINITION OF EDUCATIONAL OBJECTIVES

Just as lamentable, at times, have been other more serious

educational and training efforts for older groups. Some have almost reached the ludicrous heights of training displaced office workers in the use of tools, and displaced carpenters and machinists in office work. Even when the design has not been vocational, serious mistakes have been made in teaching older people hobbies they cannot follow because of the prohibitive costs of tools and materials. Such occurrences may be so rare that even to mention them borders on exaggeration, but their existence at all should cause educators to pause and to consider the paths they follow.

By and large educators do not know how to help middle-aged and older people meet the problems that come with age. The concern of education has been predominantly with childhood and youth. Here the purposes are clear. The child and youth are helped to adjust to the demands of the society in which they will live, be citizens, work, and play. They are given skills in the language arts, information about their world and the people who inhabit it, a knowledge of the history of mankind and, in particular, that history which develops a love of their country within them. For richer living they are given skills and appreciations for the arts and crafts of their culture. To all of this is added encouragement, and at times training, for the acquisition of vocational competency. Modern educators—old line, die hard critics to the contrary — have become enormously clever in accomplishing their aims and unbelievably successful *in teaching* even those individuals with major, pitiful handicaps. But educators have not had the time, the effort, nor the money to develop the same kinds of successful educational experiences for adults. Little is known about the psychology of adults or the learning abilities of adults in comparison to that which is known about child psychology and good educational procedures with children. Few ef-

forts have been made to create materials specifically suited to the needs of adults. Far too little attention has been centered, in addition, on the environmental needs of adults in an educational situation. Then, too, practically no direct action has been taken to tear the social and economic problems of adults into component parts as the basis for educational programs which can assist them in meeting their persistent problems. Education for adults has been and to a large extent still exists as a second chance for them to pick up things they missed for good, bad, or indifferent reasons when they were children, teen-agers, or young adults.

This does not add up to any reasonable kind of educational program for adults. Yet, with few exceptions, adult education has been and is constructed on such insecure foundations. Credit requirements for matriculation or acceptance into a lower school, sequence of courses, standardized time requirements, textbook-centered courses or syllabus-ridden classes, fragmented presentations, formal examinations, grades, and reports, in fact all of the administrative paraphernalia and frightening formalism of school life designed to impress and stimulate children with the pressure of daily assignments and the fear of the whiplash of tests linger on in the "second chance" or the extension services of public schools, business colleges, and university extension centers. Where leaders and groups have been strong enough to break with the drag anchors of such restrictions, adult education programs have frequently grown with a new vitality and promise. Here, at least, there has been a testing ground for new ways of helping adults meet the problems they face.

Just as the general adult education program is handicapped by the shallow depth of specific studies and by the scarcity of sound reports on experiments within the field,

so, to a far greater extent, is any particular part of it. Adult education, to be sure, is the logical base for an educational program intended for middle-and older-aged people, but, because of the newness of its own search for intelligent techniques, materials, and areas of service, its greatest contribution for the immediate future to the development of programs for the older-aged groups will probably be in emphasizing the need for research to uncover the true nature of the problem involved and the best ways of developing sound programs. If it approaches the task with this sense of limitations, and a desire to look before it leaps, adult education may make a signal contribution to this particular part of life.

FACTORS TO BE CONSIDERED IN PROGRAM PLANNING

Among the critical and sensitive factors for adult educators to consider in their plans for programs for middle- and older-aged groups are the emotional pressures that exist on every side. For example, older-aged groups have some of the characteristics and many of the needs of minority groups. They find it difficult to secure employment, and often find it difficult to keep employment. They find it difficult to gain the attention of a general audience. They find themselves in the position of recipients who are supposed to be grateful for what they get *whether they* like it or not. They are treated as people who are to accept decisions rather than as those who are to make them. At the top level they secure sympathy and at the lowest level they are ignored. Indeed, old people are rarely accepted in terms of their individual worth, as is any other member of the community. For such reasons and others of a critical nature older people present particular emotional problems

that educators need to know about far more thoroughly than they do.

Any rapid review of experiences gained so far in programs for older people shows additional dangers that are recognized but only superficially comprehended. To what extent do old people look for and fall an easy prey to paternalistic service? Does the attendant dependency that grows under such conditions help or hinder the individuals? Do such conditions, in addition to a vague realization of minority status, tend to make older-aged groups ready to follow any leader with a plausible promise of "better days?" What is the temptation to freeze designs when some bright programs click with older-aged groups? Are social and educational pressures growing so rapidly for programs for older-aged groups that the little research that is being conducted in the field may find itself compartmentalized, specialized, and lost to practical educators? Will old people become so quickly conscious of the potentialities of their organized political powers that they will begin demanding concessions and services long before any studied approach to their real problems can be made?

At the same time that caution must be taken to see the educational problem in its true perspective, it cannot be forgotten that education with all its limitations is still the most powerful tool that man has at his disposal to make a better life for himself and for others. Age, in itself, is no barrier to teaching new skills, to presenting new information, to helping formulate answers to bothersome problems, to exploring interests, or to the acquisition of better insights. Education has much, in this sense, to give older-aged groups. Any analysis of its limitations and its needs should not be seen as a block to a well-conceived and desirable program.

NEED FOR CO-OPERATIVE EFFORT

Educators are more mature than they used to be. Today, they tend to think of what is involved and what resources are at their disposal before they commit themselves too deeply. To the extent that this will lead to a careful study of the comparative values of different kinds of programs, of different aspects, and of the depth of needs, and of the possible use of different techniques of instruction, this caution is good. Likewise, educators are no longer willing to walk alone. They have found the strength to be derived by consultation and close co-operative work with others who are concerned, such as the old people themselves, doctors, social scientists, and other leaders of social, religious, political, and economic life in the community. This also is good because it is becoming increasingly obvious that education for middle- and older-aged groups cannot become isolated as some special program designed to be administered after the impact of the later years strikes the individual. Education for the later years must then become part of the entire fabric of education, in fact of our whole cultural pattern, if we are really serious about meeting the perplexing problems of the middle and older years. For the immediate present, there is no more important step to be taken than for educators to encourage the formation of research teams of cultural anthropologists, historians, psychologists, economists, and educators to work out the dimensions of the problem. Only in this way can the grand resources of all education be brought to bear upon the many distinct facets of the problem at the correct age levels and at the most significant points in our culture. Then, truly, educational programs for the later years could begin to help our culture salvage untold wealth that lies abandoned in the foolishly discarded human resources that continue to exist in the

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EDUCATIONAL PROGRAMS FOR OLDER PEOPLE

Education, as referred to here, in its purest form is a natural outgrowth of an intelligent reaction to a real life situation. We do not know why something happened, or we are concerned over what may happen, or we become involved in what is happening, or we want to learn how to do something and, as a result of any or all of these situations, we take steps to become better informed, or to find and evaluate answers, or to acquire skills with tools or instruments, and the know-how of techniques. Thus, we begin to exercise some control over our behavior and the way we are living, and the way we will live. At times we seek the guidance and advice of others, and the help we can secure from reports, pictures, and charts. Perhaps we even go to a professional teacher, or to a school where many others may be seeking to accomplish the same things we have in mind. In any of these reactions the distinguishing common characteristic is a deliberate and planned attempt to learn how to live better or more comfortably, and more intelligently.

Education, thus conceived, rescues learning opportunities from the incidents and accidents of pure chance. Obviously, too, it is not a way of life that is the exclusive possession of any one group or any particular age. The infinite value of this method to improve life has led man to formalize, ritualize, and institutionalize it into a nearly helpless existence, often far removed from the very life which gives it meaning and whatever value it may have. It is thus doubly important for adult educators not to lose sight of the most important basic values of education — those that are associated with making it possible to live life better here and now — to meet the physical, mental, and spiritual needs of the day. There is no better way to help children develop than to give them the skills, information, and the desire to live

their own lives fully, to meet their own problems intelligently, and to plan the systematic development of their information, knowledge, and habits in terms of goals that are clear and acceptable to them. That which is true in education for children is also just as valid for adults. Education is as potentially significant to them as to anyone else. No matter how old a person becomes, if education, conceived of as organized, deliberate, and continuing, has become a functioning part of living then life can become richer and fuller. Likewise, an education which is formless and directionless, or an education which is detached from reality and formalized and routinized is just as ineffectual for adult groups as we have found it to be for children. For both young and old that education which is based on the needs and the interests of the life which is being lived at the time is the best. No amount of administrative folderol or formalism can or should be allowed to alter this.

While it would be difficult for adult educators to tell individuals of advanced years what specific programs of study or training would be good for them, it would not be wrong to offer, on a voluntary basis, courses and programs designed for older-aged groups. There is an ever-increasing body of helpful information about living through the older years that could be presented to any interested group. Educators have a responsibility to organize this material into understand [illegible] known limits, any adult group how to use tools for vocational and for art and craft work. Here, too, they have a responsibility to help older adults where they need and request help. Such offerings do not violate the strong and desirable principles of voluntarism, but they do stimulate interest and provide ready and worth-while services. When-

ever possible, such services should be presented through skilled and experienced counselors. The greatest contribution that adult educators can make at this time, however, is to focus the attention of our entire population on the need for careful studies which will reveal the full aspects of the social, economic, and political problems of middle- and older-aged adults.

CONCLUSION

Adult educators cannot solve the problems of the middle and older years of life. They can, however, work with other social scientists toward a clearer understanding of the origin and the dimensions of the problems of these people. Studies, for example which show (1) the existing needs and expressed interests of older adults, (2) social, economic, political, psychological, and physiological causes for these, and (3) the possibilities of educational programs for older adult groups in terms of existing materials, available leaders, and successful teaching techniques. Having achieved this, adult educators can recommend pertinent changes in educational programs ranging from the nursery school through university extension programs. Then, along with other community groups and agencies, they can plan specific programs with adults concerned which will give men and women information, knowledge, skill, and even attitudes that will help them live richer, fuller, and happier lives.

PROPOSED PROGRAMS IN EDUCATION FOR AN AGING POPULATION

BY EVERETT J. SOOP

Everett J Soop, M.A, is director of the Extension Service of the University of Michigan He has carried on the interest in education for older people which was begun by the late Dr. Charles A. Fisher, to whose memory the first volume of this trilogy was dedicated. Mr. Soop is past president of the Michigan Council on Adult Education He was a delegate to the National Conference on Aging held in Washington, D C, in August, 1950

THE UNIVERSITY of Michigan Extension Service has a department devoted to the conduct of institutes and conferences such as this one on Living in the Later Years. As Director of the Extension Service it is one of my responsibilities to attend many of these conferences. One of the general criticisms of conferences that I would make is that too often a speaker on a specific topic is present only for the session at which he speaks and has no knowledge of the continuity of the entire program before making his presentation. The result is that oftentimes speakers on successive dates, or even in successive sessions, cover quite a bit of the same material, and frequently in almost the same words This is especially true in cases in which the topics are fairly general and the lines of demarcation not well delineated. With this in mind, I shall attempt to limit my presentation considerably, and certainly somewhat

more than I might if I could have known in advance what other speakers on the program would present.

SCARCITY OF MATERIAL

Frankly, in looking through the literature connected with educational programs for an aging population, it is distressing to find so little material available. Much of that which is available has been written since 1947, with here and there a few references to earlier projects such as Judson T. Landis' article in the *Adult Education Journal* of April, 1942, entitled "Adult Education and the Aged."[1] He, in turn, refers to an earlier Iowa State study of older people. This meagerness of published material thus gives me considerable latitude with a minimum of danger of duplication or contradiction.

It has been my privilege, however, to make use of (1) a newspaper release of October 28, 1949, and supplementary material from the office of State Senator Thomas C. Desmond, chairman of the New York State Joint Legislative Committee on the Problems of the Aging, (2) a paper entitled "Age with a Future" presented by Dr. Wilma Donahue of the University of Michigan Institute for Human Adjustment before the National Conference of Social Work in Atlantic City, April, 1950, and which will appear in the *Proceedings* of that Conference, and (3) copy for a pamphlet now being published by the Federal Security Agency, Office of Education, entitled "Education for a Long and Useful Life," written by Homer Kempfer, specialist for General Adult and Posthigh-School Education. These three references should be studied in their entirety, however, when they are made available, as their

[1] Judson T. Landis, "Adult Education and the Aged," *Adult Educ. Bull.*, 6(1942)·106.

approach is on a considerably broader basis than the purpose for which this presentation was planned.

OBSERVATIONS AND CONCLUSIONS

I should like first to make a few comments on my personal observations and conclusions, which relate directly to the general topic of education for an aging population.

1. The problems in the organization and administration of adult education programs for older people are basically the same as those in adult education programs for younger people. It is true that the needs of older pople are somewhat different from the needs of younger people, but all adult education programs should be organized on the basis of the needs of the group being served. Therefore, the same principles are followed in setting up or in organizing all programs. Adaptations of teaching methods and techniques may vary somewhat as may the type of instructional personnel selected, but these are merely the necessary adaptations of basic principles.

2. As in other phases of adult education there is so much work to be done in this field that the agencies—private and public, informal and formal, local, state, and national, and schools and colleges—have plenty to do and need only to plan co-operatively in order to avoid seeming duplication and unseemly competition. To be specific, I believe that in the future a major part of the programs on the local level will be channeled through the public school system. I shall mention only *two reasons* for this belief: its control of facilities and its access to finances. Plans for the construction of new schools now usually include facilities of such flexibility that they can be used by all age groups. Incidentally, this type of development should be given every encouragement. In fact, I think it is an obligation of older

people to make certain that the persons responsible for the construction of new schools in their localities be kept aware of the needs of the older group. In order to develop any program, finances have to be available in sufficient quantity to provide the necessary personnel and operational expenses. Many states are today providing funds for adult education, but with the provision that they have to be disbursed through public school systems. There are many things which the local public school cannot do for and by itself. I hope that the public school may realize this and call on the agency or agencies who can do the job and get them to assume the responsibility rather than to attempt to do everything itself. I envision that the job of the colleges and universities may eventually be to continue to provide leadership, to prepare and provide materials for the use of all agencies, to conduct pilot courses of an experimental nature, and to conduct a research program.

Since it is inevitable that a variety of agencies will be included, I should mention here that many of the projects that are described in the literature have been conducted as part of a recreational program rather than as part of an educational program. The lines between recreation and education in many cases cannot be drawn definitely, and this emphasizes the need for close co-operation between the educational and recreational departments. Certainly these two groups need to plan together, especially on the local level. Before leaving this point I mention, but without comment, that, in general, the programs offered locally by nonlocal agencies should be different from those offered by local agencies. They should be supplementary, however, and not competitive and should fit into the educational pattern of the community.

3. I now want to discuss briefly a favorite thesis of mine.

We are just ending a month in which hundreds of thousands of people have been told as they sat through graduation ceremonies that we are in the midst of a changing world and that the young people of today have responsibilities which those of yesterday did not have. They have been told that they must adjust to changing conditions and that they are living in a period which will, in turn, create many changes within them. Living in an atomic age with all of the accompanying fears and tensions, as well as hopes, ambitions, and aspirations, will be strenuous It is my contention that this same set of conditions which will change young people will also change older people. We have never had as many in this older group as at present. We speak of the older person as always being conservative. Why is this? Probably it is because our experience, if I may be permitted to generalize, has been with the "old type" older person. He was the result of the selective process which made him fortunate to be alive at more than the normal period of life expectancy. Pensions, retirement plans, and similar benefit programs had not been worked out, and he was conserving what he had earned earlier to protect him in his old age. Parenthetically, I might mention that in the community in which I grew up the social security plan for my grandfather and many others of his generation was the Civil War pension. It seems illogical to me, therefore, to think that the older person of today is the same as the older person of yesterday, especially when we agree that the young person of today is different from the young person of yesterday. The older person of today has, in the past thirty-five years, gone through two world wars and a major depression. He wants his children and grandchildren to avoid some of the difficulties he has gone through or observed He knows that he can still learn and

people to make certain that the persons responsible for the construction of new schools in their localities be kept aware of the needs of the older group. In order to develop any program, finances have to be available in sufficient quantity to provide the necessary personnel and operational expenses. Many states are today providing funds for adult education, but with the provision that they have to be disbursed through public school systems. There are many things which the local public school cannot do for and by itself. I hope that the public school may realize this and call on the agency or agencies who can do the job and get them to assume the responsibility rather than to attempt to do everything itself. I envision that the job of the colleges and universities may eventually be to continue to provide leadership, to prepare and provide materials for the use of all agencies, to conduct pilot courses of an experimental nature, and to conduct a research program.

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I am not critical of any of these activities, as they represented the best that we had at the time they were started and in many cases they still are. As stated in connection with the Hodson Community Center in New York: "Much of the physical and mental deterioration of older people is greatly accelerated by inactivity, loneliness and boredom." I might mention that in this case classes were started as the needs arose in "art, English, woodworking, leathercraft, music." [3]

Our experience at the University of Michigan has been along a somewhat different line. Our actual experience goes back to the spring of 1948, although a considerable amount of time and energy had been spent during the preceding years in getting ready for the work that finally developed. As the result of the impingement of ideas relating to the problems of older people and the acknowledgment that the University should do something about them, President Alexander G. Ruthven, Dr. Charles A. Fisher of the Extension Service, and Clark Tibbitts, Director of the Institute for Human Adjustment, discussed what the University might do and how it should proceed. Incidentally, Dr. Henry Curtis should be given considerable credit for the continuous supply of material he provided for consideration during the early discussions. To quote from a report by Clark Tibbitts:

> Preparation for life during the later periods may be fully as important as *preparation* for the earlier years. It appeared completely logical, therefore, that there should be preparatory courses for oldsters as well as for youngsters. Accordingly, in February, 1948, the University *Extension Service* introduced a course for older people — Problems and Adjustments in Later Maturity and Old Age. For further offerings, the title of the course has been *shortened*

[3] Arline Britton Boucher and John Leo Tehan, "No One Under Sixty Need Apply," *Recreation*, Nov., 1948, pp. 347-50.

that his intellectual acumen deviates little from the level of his middle years. Then too, he knows he belongs to a growing minority group and in it are persons who have the time and in many cases the money, the know-how, and the ability to get their voices heard in matters relating to necessary social measures. Moreover, they can vote. We can expect, I firmly believe, that much advanced social thinking of the future will come from this older-age group.

EXISTING PROGRAMS

Before mentioning proposed programs, attention should be called to some of the existing projects. In 1948 Homer Kempfer wrote:

> Only a few social agencies, libraries, and schools have started significant programs specifically designed for the older-age groups. Of the 100-odd clubs for old folks, possible a minority are connected with organizations with educational objectives. Titles and activities of some of the current programs are:

Aging Creatively	Grandparent Education
Armchair Travel	Book Discussions
The Art of Growing Old	Health After Sixty
Community Problems	"Live Long and Like It" Literary Club
Grandfathers' Clubs	
Arts and crafts	Gardening
Field trips and excursions	Local history
Film forums	Philosophy
Travelogues	Sketching[2]

As is readily seen, most of these titles induce in our minds a mental picture of activities planned to prevent a person from knowing that he has nothing to do and to keep him from thinking about it. Some of these activities, however, will be present in any program developed for older people.

[2] Homer Kempfer, "Adult Education for the Aging," *Amer. School Bd. Journ.*, Nov., 1948, pp. 19-20

and asked a good many questions." Incidentally, refreshments and social periods added to the interest and value of the course. Evaluation forms turned in at the end of the course "indicated clearly that most of the students obtained a new point of view about old age, as well as suggestions and assistance in the solution of individual, specific problems of health, activities, living arrangements, and financial matters." The outgrowth of the course was development of a social group which has continued an uninterrupted series of weekly picnic — recreational — social activities under the name of "Senior Citizens."

To me one of the most important conclusions was that the course demonstrated that older people want useful activity and participation in affairs with other people. It is not enough for them to be told that they are wanted; they must feel that they are both wanted and needed and that they are valuable assets to their communities. As the result of the interest shown by both oral and written inquiries and casual conversations, a comprehensive conference on "The Problems of Later Maturity and Old Age" was developed during the summer of 1948. As Dr. Fisher died suddenly in March this first institute was named in his honor. It was addressed to two groups of people: (1) professional workers, such as adult educational leaders, welfare workers, ministers, recreational workers, personnel workers, counselors, and public health nurses; and (2) middle-aged and older people alert enough to know that they can enjoy the later years if they understand themselves and the aging process and make suitable preparation. The report of this conference is included in the volume *Living Through the Older Years*, edited by Clark Tibbitts.

Since then, similar courses and institutes have been offered each year. Course topics were changed as experi-

to "Aging and Living." . . . The topics were designed (*a*) to provide specific information for immediate use in connection with current individual problems, (*b*) to give philosophy of aging, and (*c*) to afford some understanding of the relationship of the satisfaction of the needs of older people to the total social organization.[4]

In sixteen meetings the course covered eight broad fields of information: biological aging, psychological changes, maintenance of physical and mental health, living arrangements, creative activities, religion, social and economic security, and legal problems. This first course was given in Ann Arbor with an enrollment of fifty-one.

To quote from the above report:

> About two-thirds of the group were women; more than one-half still had some employment; ages ranged from 23 years to 81 years, the average being 60 years, and all but one or two had completed high school.
>
> Much of the acceptance given the course probably derived from the selection and the performance of the speakers. It was fortunate that the University was large enough to afford for each field not only an expert but one known to prepare carefully for his audience. The individuals selected were all approaching or actually in the period of later maturity. The objective of the course appealed to the speakers and, without exception, they took their assignments conscientiously.

The group met one evening each week for a two-hour period beginning at 7:30 o'clock. At the beginning of the period, outlines of the topic to be covered that evening and a form for evaluating the preceding meeting were distributed. Formal presentations usually required from fifty to sixty-five minutes; seventy-five minutes proved to be too long. Another interesting comment was: "Despite the age of the students, the evening hour following shortly after the evening meal, and the need for keeping the room quite warm, the students were alert, remained throughout each session

[4] Clark Tibbitts, "Aging and Living," *Adult Educ. Bull.*, 13 (1948) 204-11

and asked a good many questions." Incidentally, refreshments and social periods added to the interest and value of the course. Evaluation forms turned in at the end of the course "indicated clearly that most of the students obtained a new point of view about old age, as well as suggestions and assistance in the solution of individual, specific problems of health, activities, living arrangements, and financial matters." The outgrowth of the course was development of a social group which has continued an uninterrupted series of weekly picnic — recreational — social activities under the name of "Senior Citizens."

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ence indicated. The 1949 institute was more specific in the topics considered, focusing on housing, living arrangements, creative leisure-time activities, and employment and employability. As in 1948, much of the material of last year has been published in a volume entitled *Planning the Older Years.*

Through the co-operation of the Institute for Human Adjustment, and with Mr. Tibbitts first, and then Dr. Donahue, serving as co-ordinator for all of the courses and the summer institutes, programs have been conducted by the University Extension Service in Detroit, Grand Rapids, Jackson, and Flint, and assistance has been provided to many other communities. One of the criticisms that might be made of the course is that the fee charged probably prevented many in the lower economic levels from attending, although they could probably have benefited by attendance. A suggestion was made that the older people would like to get together to discuss some of their more personal problems under circumstances involving fewer persons and with a discussion leader chosen from the group.

Another result is that we believe that courses should be planned for at least three different groups: the older people themselves; those who are in their middle years and who are planning for their later years and/or have family problems relating to older people; and professional people.

In Windsor, Ontario, across the river from Detroit, a somewhat similar program was conducted by Dr. R. B. Robson, medical director of the General Motors Corporation of Canada, Limited, in connection with the older workers in his organization. In a printed report, Dr. Robson gave the following results of his experiment:

Every working man who attended these classes has been interviewed and the following reactions resulted: (1) The series of dis-

cussions was well received by all (2) Each man expressed the hope that similar lectures would be carried on next winter. (3) The men talked with their wives about subjects that had previously not been discussed. (4) Many men brought in clippings from papers and magazines dealing with later maturity (5) Opinion was given that the age limit of classes should be lowered from 45 and even made shop-wide (6) A preliminary talk to a foremen's meeting, explaining the aims and objects of the course, would have given better publicity. (7) The sympathetic leadership of management and the enthusiastic support of the chief steward of the Union were prime factors in the success of the experiment.[5]

This project was probably one of the best for reaching industrial workers, for developing among them an awareness of their need to prepare for later years, and for conditioning the minds of employees in a huge industry about the problems of older workers. Probably this function of developing awareness in the minds of the general public is one of the greatest needs of today.

In a nation-wide survey covering the year 1947-48, only twenty-five public schools listed "special activities" for people past retirement age. As reported in "Adult Education Activities of the Public Schools," *Office of Education Pamphlet*, No. 107: "Reports, publicity material and requests for assistance to the Office of Education indicate that the number of school adult programs providing activities for the aging is growing rapidly." Some of the places listed are several communities in California; Fort Lauderdale, Florida, Story City, Iowa, Wichita, Kansas; Springfield, Massachusetts; Stephenson and Kalamazoo, Michigan; Johnson City, New York; Bremerton, Washington; and New York City. Invariably, reports of these activities indicate the need for general dissemination of information about

[5] R. B. Robson, "Experiment in Education of the Older Workers," *Indust. Med.*, 18 (1919) 365 67

ence indicated. The 1949 institute was more specific in the topics considered, focusing on housing, living arrangements, creative leisure-time activities, and employment and employability. As in 1948, much of the material of last year has been published in a volume entitled *Planning the Older Years.*

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were planning definitely to add specific courses, six were planning tentatively; and twenty-eight were integrating the material into other courses. Of the thirty-two colleges of education reporting, only two were then offering specific courses. Fifteen others indicated that they were adopting a plan of integration with their current offerings. From this report, it is easily discernible that only a few of the professional schools have launched definite programs in gerontology.

In a survey of 486 colleges and universities, in 1949, the results of which have not yet been published, the New York Joint Legislative Committee found that 463 had no special courses but that considerable material was being included in such fields as sociology (234 institutions); psychology (75 institutions); and economics (104 institutions). The American Psychological Association questionnaire, previously mentioned, was sent to only seventy-six college psychology departments. Sixty replied. Three offer specific courses; four are definitely planning such courses; three are planning tentatively; and twenty-four integrate the material with current offerings. In the committee survey, eleven universities listed specific offerings of either courses or special institutes and conferences — California, Chicago, Denver, Louisville, Michigan, Missouri, Tulane, Marquette of Wisconsin, Washington of St. Louis, Wayne, and Wisconsin.

The New School for Social Research, New York City, also listed special courses. Harvard, Boston, Tufts, Northwestern, and Massachusetts Institute of Technology reported a jointly sponsored radio program. According to reports collected by Wilma Donahue, fairly recently, initial programs are being offered for older people by the University of Illinois and Western Reserve University. New York Uni-

the problems of our aging population. There is no question about the need for expanding all of these programs.

In the professional field very few courses focus directly on the problems of the older person. An examination of the 1949-50 catalogues of approximately sixty schools of social work showed that five listed special courses with most of them in the case-work field or with case-work implications. The course at Tulane University was entitled "Age Differentiation and the Group Work Process"; at the University of Minnesota, "Maturity and Age"; at Louisiana State University, "Needs and Problems of Aged Persons"; at the Catholic University of America, "Social Services for Older People"; and at the University of British Columbia, "Seminar in the Problems of Old Age." It seems probable that the next few years will see many of the remaining schools of social work adding similar programs to their curriculums, although at the present time the tendency is to integrate such course material into the regular curriculums. Certainly there is need to develop in the minds of prospective social workers an awareness of the problems of the aging and sympathetic approaches to older people. Here again I point out that there is need for development of new, or adaptation of old, methods of approach to this group of people.

In a report of the Committee on Instruction for Maturity and Old Age, Division of Maturity and Old Age of the American Psychological Association, printed in the *Journal of Gerontology,* the results were given on a questionnaire sent to seventy-one medical schools and sixty-two colleges of education.* Of the fifty-two medical schools that replied, five were then offering specific courses in geriatrics, three

* "Courses of Instruction on Maturity and Old Age." *Journ. Gerontol.,* 3, No 3 (1948) 225.

were planning definitely to add specific courses, six were planning tentatively; and twenty-eight were integrating the material into other courses. Of the thirty-two colleges of education reporting, only two were then offering specific courses. Fifteen others indicated that they were adopting a plan of integration with their current offerings. From this report, it is easily discernible that only a few of the professional schools have launched definite programs in gerontology.

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versity, the University of Minnesota, and Syracuse University have added courses for professional workers.

I am also indebted to Wilma Donahue for the following list of institutions and organizations now conducting research projects on problems of the aged: Bryn Mawr College, University of Chicago, University of Michigan, Ohio State University, University of Pittsburgh, Rockford College, Sweet Briar College, Syracuse University, University of Rochester, the United States Public Health Service, Chicago Community Social Agencies, and the Federal Council of Churches.

No list of educational programs would be complete if the projects conducted by many other agencies were omitted. Libraries, recreation departments, and councils of social agencies are all playing important roles in this new field that cuts across practically all community lines. Much praise should also go to the New York committee headed by Senator Desmond for its intensive investigations of the problems of older citizens. Over and over again, the educational tasks to be done have been discovered and pointed out by these special agencies.

PROPOSED PROGRAMS

This is the time for educators and others responsible for educational programs, or programs having educational implications, to give free rein to their imaginations. Our present methods do not begin to keep pace with our expanding clientele. Just what can be proposed with some hope that the proposals can be accomplished?

Greater use of mass media. First of all, we must make more use of the mass media — radio, television, films; I would even add the comics, for I believe they can be utilized to tell the "conditioning" story to many who can be

reached in no other way. At Michigan we hope to continue experiments with radio programs and the possibility of developing listening and discussion groups within the range of the University station. Many of our programs will be put on tapes or on records, and these will be made available to other radio stations At the present time we are having many requests for the programs already given. Then, too, plans for greater use of records offer a possibility for experimentation.

If a program is developed with outstanding authorities presenting their specialties, it is illogical to make use of such persons with only one group, and that possibly a small one, or for only one presentation. A record may be made and used as an introduction of the topic for a group discussion. Here again the development of new groups or the utilization of those already in existence offers a possibility for experimentation. It is greatly to be hoped that leadership in gerontology will continue to come from the colleges and universities. These proposed programs may, therefore, be more likely to be developed by such institutions than by the public schools and other agencies. It seems logical that programs or projects that prove themselves on an experimental basis will be initiated wherever the results are known. As stated earlier, the public school and other community-wide agencies will probably be the channels to the general public.

Those of us who are connected with educational institutions probably have a sizable amount of pioneering, evangelistic zeal in our blood. Each knows his own institution, its peculiarities of administrative organization, and the eccentricities of its faculties. In some cases a direct approach can be made, in others entrenched interests will indicate that only an approach on the bias will have any chance

to succeed. Some of the items to be included in a developing educational program are mentioned with the understanding that their location within institutions will vary considerably.

Vocational education. Even in those vocations in which it is possible for the older person to continue his activity, but in a somewhat different manner, it is often necessary to give him new, different, or supplementary training. In staffing some of the suggested projects, what better source for personnel could we have than older people who have had special training and/or experience in the areas included in those projects? The college professor is not always able to adjust immediately to the difference between adult students and campus students. Many of these adults have had wider experience than he has had. His approach to them has to be different; instructors in college examine the student, but in adult education the students examine the instructors. Similarities exist in cases of the other professions, such as law, medicine, the ministry, and so on. Therefore, in setting up educational programs in the vocational field, plans should be included to supply such supplementary training as may be necessary. Workshops or seminars will possibly be the most satisfactory techniques for this purpose.

Surely there will also be an expansion of programs to train older people for new jobs. It is my belief that industry or business itself will eventually provide much of this type of educational program.

Counseling facilities. Need for counseling services is voiced over and over again, and yet we have no general counseling centers or clinics with a well-trained, sympathetic, understanding staff dealing only with the problems of older people. Providing training for such

personnel may be a responsibility of the department of social work. On the other hand, the psychology, sociology, or education department may be training counselors. But, whatever the agency, the program needs expanding to include the provision of this necessary training.

Professional programs. Some of the professional schools of medicine, public health, nursing, education, religion, and social work have already begun programs planned to give their students specialized training relating to the problems of older people. Every encouragement possible should be given to them and to other institutions that evince interest in developing programs.

Nonprofessional programs or programs for adjustment and understanding. Courses planned as part of a continuing education program should be available for all adults regardless of age. Certainly, education in every stage should build on the habits and learning skills ot previous stages. Only in this way can deterioration of these habits through disuse be prevented. Here again I should like to quote from "Education for a Long and Useful Life":

> The educational program for each individual should be focused primarily on the years immediately ahead – to help him adapt his life to the biological changes and new human relationships that confront him. It should be concerned with what might be – not what might have been.
>
> Services for the older age groups should be a total community responsibility and educational planning for and with them should be an integral part of the total community attempt to meet the needs of an aging population.[7]

General education. This is the area in which we strive to keep people in touch with today's new findings and happenings and their implications for our tomorrows. Such

[7] Homer Kempfer, "Education for a Long and Useful Life," *Office Educ Pamph* (Washington, D. C.: U. S. Govt. Printing Office, 1950).

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Vocational education. Even in those vocations in which it is possible for the older person to continue his activity, but in a somewhat different manner, it is often necessary to give him new, different, or supplementary training. In staffing some of the suggested projects, what better source for personnel could we have than older people who have had special training and/or experience in the areas included in those projects? The college professor is not always able to adjust immediately to the difference between adult students and campus students. Many of these adults have had wider experience than he has had. His approach to them has to be different; instructors in college examine the student, but in adult education the students examine the instructors. Similarities exist in cases of the other professions, such as law, medicine, the ministry, and so on. Therefore, in setting up educational programs in the vocational field, plans should be included to supply such supplementary training as may be necessary. Workshops or seminars will possibly be the most satisfactory techniques for this purpose.

Surely there will also be an expansion of programs to train older people for new jobs. It is my belief that industry or business itself will eventually provide much of this type of educational program.

Counseling facilities. Need for counseling services is voiced over and over again, and yet we have no general counseling centers or clinics with a well-trained, sympathetic, understanding staff dealing only with the problems of older people. Providing training for such

that too much time is being spent on older people and their problems. Business, industry, and labor are becoming aware; the professions and public agencies are awake; but the general public lags far behind. Education must not only keep pace with progress, it must keep ahead of that progress and point the way. Every means at our disposal — radio and the other mass media, newspapers, periodicals, study courses, conferences, institutes, lectures, discussion groups — should be used to focus attention on this large group in our population, on their problems and needs, and on the important and necessary roles they play in our communities.

widely known but divergent personalities as the economist Dr. Millard Faught and Billy Rose agree that education is probably the most obsoletely merchandized commodity in our society. As I mentioned earlier, classes, small discussion groups, and the other formal methods we have used in the past for the dissemination of information and knowledge, as good as they are, are just too slow for this age of almost instantaneous world-wide communication of catastrophic news, of distances measured by time rather than by miles, and countless other breath-taking daily occurrences of this atomic era. I repeat, here is where creative imagination and inventiveness in education are needed. Older people, like younger people, want to know what is going on about them. If they are provided with the opportunity to know and if they have been active participants in the formaion and creation of plans whereby the opportunity is provided, we can minimize the possibility that they will fall prey to demagogues and false prophets. They will be mature intellectually as well as physically.

Special service programs. There is considerable evidence of a demand for specialized training programs for convalescent home, nursing home, old people's home, and infirmary personnel. Present indications are that the needs are for seminars and workshops rather than for courses. Here is another opportunity for educational institutions that have the facilities and the personnel qualified to offer such training.

Public information. Every institution and agency can play a vital part in stimulating interest in the problems of older people. Very little will be done until the general public has an awareness of gerontological problems, and of the speed with which they have been and are developing in all our communities. We disagree with those who tell us

TRAINING FOR VOLUNTEERS IN COMMUNITY SERVICES WITH OLDER PEOPLE

BY OLLIE A. RANDALL

Ollie A. Randall, A.B., is consultant on Services for the Aged, Community Service Society of New York City. She is chairman of the Advisory Committee and of the Conference Group of the Bureau for the Aged of the Welfare Council of New York. She is a member of the Advisory Committee on Care of the Chronically Ill and Infirm to the New York City Department of Hospitals and a member of the advisory editorial board of the Journal of Gerontology. *In addition, she is general adviser for the New York State Joint Legislative Committee on Problems of the Aging. For twenty years she was assistant director of the Department of Special Services which administered such programs for the aged as Ward Manor, Tompkins Square, and the Crawford Shops. Miss Randall is past president of the New York State Conference on Social Work and past chairman of the first conference section on the aged of the National Conference on Social Work. At the National Conference on Aging held in Washington, D.C., in August, 1950, a citation was presented to Miss Randall for pioneering in services for the aging.*

DEMAND FOR COMMUNITY SERVICES WITH OLDER PEOPLE

THE GROWING demand for community services with older people has several notable characteristics. Among these are undoubtedly the overwhelming size of the group to be served, and the almost total lack of experience in rendering services adapted to persons who have already lived the

munity. They, too, have felt the mark of Father Time's fingers, and from their own maturity comes a new sensitivity to the possible validity of the calls for service. Whether this be an advantage or disadvantage may be a moot point, but community action which leads to special new services for those of us who are in the upper age brackets, and which will adapt existing services so that they will be available to both the middle-aged and the aged cannot safely be delayed any longer.

HANDICAPS TO WORK WITH OLDER PEOPLE

Work with older people is handicapped by a number of things, chief among which is the traditional prejudice about old age and old people. The common thinking about any kind of work with them, whether of a professional, volunteer, or family nature, is that it is simple and requires little beyond satisfying the elementary needs of shelter, food, and some care which does not require any particular skill. If kindliness can be an element in the service, that is just so much gain. The most frequently expressed concept of the manner in which one treats old people successfully is that "all one has to do is treat them like children!" I can think of no better service to old people anywhere and everywhere than to re-educate the public on that one point alone — to disabuse them of the truth of this idea. Children have not lived as adults in a world which has buffeted them about. They have *not* built up a lifetime of experiences to which they have reacted and by which they have been molded into the personalities with which we must become acquainted. Even when oldsters regress somewhat, as they may do in different stages of senility, there remain visible vestiges of their past which often determine their response to treatment. And I often *wonder, too,* whether these people who think

major part of their lives. Then, too, this lack of a sufficient volume of experience with such services makes it difficult to judge wisely as to what is desirable and suitable for the future. One obvious characteristic is the lamentable lack of workers, either trained or untrained, paid or volunteer, for even those services which are at present envisaged as practicable and essential for the well-being of the older people and of the community. With this situation confronting almost every community, the generally accepted conclusion is that there is a greater need for volunteers in this field of activity than in almost any other.

For those whose community experience dates as far back as the early thirties, there is much in this unpreparedness for a mass job with oldsters which is reminiscent of those early desperate days of undertaking to organize public welfare programs for the relief of the unemployed. There was little experience by which to be guided; there were no workers trained for the exacting demands of the work; the job was tremendous; and it had to be done. To those of us who knew that period and have also struggled to cope with the problem of old people in an aging population, on a personal, professional, and community basis, there are in this, too, some of the same qualities of urgency and emergency which those other days had. It still fails to stir the same kind of emotional response or community action from the general public, however, probably because it has come upon us with much less drama, and like old age itself is suddenly, without any ringing announcement or loud warning, quite irrevocably with us. Yet to my mind we have real reason for hope that something will soon be done. That hope depends on the very appreciable shift in the age pattern of the group of people in any community — local, state, or national — who are responsible for action in that com-

munity. They, too, have felt the mark of Father Time's fingers, and from their own maturity comes a new sensitivity to the possible validity of the calls for service. Whether this be an advantage or disadvantage may be a moot point, but community action which leads to special new services for those of us who are in the upper age brackets, and which will adapt existing services so that they will be available to both the middle-aged and the aged cannot safely be delayed any longer.

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that relationships with older people are simple because of this similarity to children pause to think twice about all that we now know about the behavior of children, of the complexity of their natures, and of the favorable or detrimental effects of different environments upon them. Perhaps in time this knowledge will be correlated with that of the behavior of adults. Then there may be a better understanding of what is needed continuously throughout all of life rather than depending as we do now on the fragmentation of the life span into all its several "ages," with specialization for each, as though no one period has relation either to that which precedes it nor that which is bound to follow.

LACK OF EXPERIENCE IN VOLUME AND PROFESSIONAL CONTENT

One of the serious complications in planning for training of either professional or volunteer workers is that, in the first place, there has been all too little actual experience in the several fields of endeavor to have developed a sufficient or significant volume of training material. In the second place there has been a very limited opportunity for professional observation and participation, so that the experience has been subjected to almost no effort to crystallize working principles for either teaching or training purposes. As the appreciation of old people as people, who if physically and mentally well, retain all the rights and responsibilities and needs which were theirs in earlier life, grows with both lay and professional personnel, there is beginning to be a concentration of effort to build up definitive material which will help to guide all of us in our work with oldsters. It is in this process that the help of the educators can be invaluable to us. While experience is a valuable teacher, it may at times be costly as well, unless there be brought to bear

upon it keen analysis and judgment as to what constitutes merely opinion and what may be counted upon as factual data. Scientific methods of substantiating observation and conclusions based on experiences are lacking in this field. It must be remembered that many of the persons who have engaged in work with older people for a long period of time, mainly in institutional care and in public welfare programs, have carried on their work without benefit of formalized preparation or training. In the institutional work all that was once necessary (and sad to relate all that is too often necessary even now) was that a person be kindly and in need of a job in order to qualify for it. In the latter programs many of the workers came into them at a time when intelligence and the need of a job, together with residential qualifications, were about all that it took to be eligible. That situation is, however, now somewhat more stabilized, and educational requirements are higher. These, together with inservice training and institutes, are responsible for much of the improvement in attitude and in the caliber of service in some of those programs which reach the thousands of elderly people who must receive public assistance.

OPPORTUNITIES FOR SERVICES

The opportunities for rendering service to older people are infinite in both number and variety. It is impossible to inventory them completely. The first are those which exist in the home of the old person. If there can be recognition on the part of members of the family that here indeed "charity begins at home" a genuine start will have been made toward relieving some of the tensions and difficulties which the old and the young alike are likely to feel. And for this, as well as for the service to neighbors, friends,

and strangers, there can be training which will make life easier for all concerned.

Visiting services of all kinds are of untold value to the older person, whether he be living with a family, alone, or in some other kind of living arrangement where he is dependent upon others than his own kin for care and service. The visitor may come for the purpose of a friendly call, purely for the sake of sociability, which is in itself purpose enough. Or the call may be made to render a specific service, such as some social or nursing service, or even that of performing some housekeeping task which the older person cannot do. It may be to do some errand for the individual, or it may be to bring a book or some gift or gadget to make the day brighter.

The epidemic of clubs and recreational centers which is rampant at present provides all kinds of ways of being useful as a volunteer. The clubs are in need of leaders for groups, of teachers of specific crafts, of people who will help to organize and to secure financial support for the activities, of people who will supply the almost unlimited requirements for equipment and materials with which to work, of people who will develop community enthusiasm for the activities through all the media now used in public relations, and of people who will serve on boards of directors and take responsibility for continuity of service of both staff and volunteers. There is hardly a single skill which cannot be used in some phase of the work with groups of older people.

In both the public welfare and private family agencies the need for volunteers who will relieve workers of many of the details which do not require the specific skill of the trained worker is a crying one. To clarify what is work for the volunteer and what can only be carried by the staff

workers is not so simple as it would seem. The task of interpretation to the volunteer of the differences and the reasons for them is one which calls for unusual perception and experience. This same holds true for the immense variety of services which a volunteer can render in a hospital setting, especially for older people, generally the most unwelcome of the patients to be admitted and the least wanted of those who remain. Case work aides in the social service department, nurses' aides, library aides, aides in the clinics, in the occupational therapy rooms, in the rehabilitation units, and with those who provide entertainment for the long-term patients, are all needed in numbers which far exceed the available supply. To be an aide in any one of these services consists of more than reporting for duty, for each is a specialty of its own, and there are, within the hospital setting, functions which belong to each and which are most carefully related to the other professional services which the hospital and clinics provide. The question might easily be raised as to whether these are not generalized needs for volunteers, and the answer would be "yes," but over and beyond that there is in every one of these services a need for persons who will be especially trained to understand and to serve the elderly patient.

Homes for the aged in any community have traditionally used volunteers, for boards of managers have looked upon the management of the home as their "charity." But here too there is a change in the approach to this type of volunteer service. There is a growing awareness that managing an institution or a home for the aged in which elderly people live for twenty-four hours out of every twenty-four requires a high degree of professional training and skill, if it is to be well done. But there is still plenty of room for the volunteer — the friendly visitor, the leader of group

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clear line of demarcation between the secular and the religious elements in our services as this would seem to indicate. The social isolation of many oldsters means in too many instances spiritual isolation as well. A nice combination of the two kinds of services under church auspices will do much to reduce the total isolation of older people by bringing them into the circle of activities which make for normal friendly associations with others.

In the educational world also the sky seems the limit, at least at present, if we wish to use the abilities and energies of people with the will, the ability, and the wish to serve others, all of which are wasted commodities in a rashly extravagant society What is needed here is to study how the knowledge of available people can be formalized enough to be used with a minimum of loss and a maximum of gain for those serving and those to be served through adult education. Once educators have discovered the process for this, the way will be clearer as to how to use volunteers more effectively in our efforts at community organization and in achieving social action.

TRAINING THE VOLUNTEER

This is but a partial, and rather a dull, list of possibilities of volunteer service. What is there about them which demands training, and how does one go about giving or getting such training? The topic seems to me to divide itself logically into three parts· who should be trained as volunteers, what should be the content of training, and how should they be trained.

THE "WHO" OF THE VOLUNTEERS

In communities in which the demand for help is great and the supply of workers is small, there is a strong temptation

activities, the person who can stimulate the residents to service for others, and who can use her personal warmth and human understanding to help create the atmosphere of "home" which each resident longs to have, no matter where he lives.

Then, too, there is always the matter of easy transportation to and from hospitals, theaters, church, and shopping which can make all the difference between a successful journey for the older person and a day of misery and discomfort. It may also mean all the difference for the old person between a journey into the community and staying at home, feeling bitter, lonely, and frustrated.

The library presents another simple opportunity for service which is often overlooked. Many older people cannot get to the library — and from a public library which cannot afford such delivery a volunteer delivery service of books which are of good print and are of interest to the recipient can take the place in urban centers of the traveling libraries which are becoming more and more common in our rural counties throughout the country. In library centers the work with book clubs, discussion groups, with concerts from musical records, which are for older adults the counterpart of some of the children's storytelling hours and teen-age "jazz sessions," offers a rare opportunity for those with the educational background for making this kind of experience profitable for everyone.

The church is another of our institutions in which there is a wealth of opportunity for volunteer service. The church has always counted on volunteer help for most of its activities. Thus, it is in keeping that these be devoted to work with older people and that older people find in them a place for service to others. It has been said that social work is the secular arm of the church, but there is no such

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those who are presumably to be helped. This liking, artificial if you will, does not always stand up to the test of old age in its multitudinous manifestations as they are encountered in programs primarily directed toward serving older people.

Volunteers must themselves be secure and mature, if they are to communicate a sense of security and maturity to others. They must be prepared for continuity of service, for there is nothing more defeating for older people than to continue to sustain losses in friendship and acquaintance through constant changes in volunteer staff in addition to those losses which most of them have already sustained. There is no hard and fast rule as to the age qualification, but it is well to keep in mind that a group of old people, or even a single elderly individual, can be as quick to detect a false note — uncertainty, immaturity, insecurity, boredom, or of patronage — as is a child to sense whether he is genuinely liked. They have become more sensitive to the overtones and the undertones in personal relationships than most of us who are so busy with our own affairs that we do not need to be so alert to the fine shades of feeling as they have time and reason to be.

Volunteers must also have the capacity for being sympathetic without being oversympathetic, concerned but not unduly concerned, helpful without being too helpful, and possessed of a respect for the individual old person and his culture without having to justify that entirely by what might be called an acquired tolerance. It is a nice balance which must be held — for all too often do we hear the criticism that training drains off the milk of human kindness and leaves hardened hearts and closed minds. These are as devastating as overindulgence in emotion, which training helps to control. And one thought further — which is, of

to take the path of least resistance and to use anyone who indicates an interest in work with older persons. But while that way lies an immediate easing of the crisis, there also lies the possibility of future difficulty unless care is exercised at the outset to observe and to train.

Probably the most obvious group to whom any community can turn is that composed largely of older people. The reasons for this are self-evident. There is an identification of interest. There are likely to be more of them, with more free time to devote to volunteer effort. And they are likely also to have an understanding and skill which will be priceless if properly directed and used. The tendency has been to think these qualifications are enough, but our brief experience indicates that this is no more the case in volunteer work with older people than with other age groups. Therefore the criteria for selection must be used as carefully with this potentially effective group as with any other.

Now that work with older people is beginning to be more popular it is possible to be somewhat more selective. Not everyone is personally qualified to be involved in this work. A volunteer must in truth be a paragon — for she must have all the qualities which the professional worker wishes she had, in addition to the kind of altruism which prompts her to give of herself freely and consistently to that work for which the staff worker is paid. There is no gainsaying, however, that to be successful with old folks people *must have, more than any other one thing,* a liking for old people which is genuine and which is of long standing, with roots in a feeling for and a feeling with oldsters. Too many people are now finding themselves with what I call an "intellectually stimulated" liking for old folks because this seems to provide an entree to a new field of activity which will be of more help to the helper than to

understand that at times when he cannot make the grade or reach the goal he may have set for himself, there may well be factors beyond his own power to control. We all need the kind of sensitivity which John Hersey gives in his dramatic novel *The Wall*, about which he says it was his business as novelist, not to illuminate the events but to illuminate the people caught up in the events And people make up the aging population. They are real; they are human; and while they cannot be helped merely by seeing themselves as part of a large mass of the populace, they may be given a new sense of their relation to that group by some careful explanation of the force which is unavoidably affecting everyone of us.

Second, there must be orientation to the need for understanding old people — understanding them as members of a group which has been disadvantaged by events, and as persons who have little more in common than that they have lived approximately the same number of years. There must be understanding of the new potentialities of older people that are inherent in the scientific knowledge at our disposal, which has not been applied as comprehensively nor as intensively as it can and should be. But understanding of the human being who has in no sense lost his human qualities and his human longings because he has reached a certain point in his lengthened life journey will, if it is sound, soon beget the kind of objective sympathy which volunteers must have if they are to serve wisely and well.

Third, there must be orientation to current thinking as to personality development and adjustment, as to family relationships, as to financial status and ways of maintaining economic security, through employment or the social compromises available, as to ways of living, as to health and

course, a statement of the obvious — that persons who cannot be effective in one type of service are often invaluable in some other. The great difficulty is that most people wish to "work with people," and are often unable to accept the fact that their peculiar ability may lie not with the people but in the work with what one of my early advisers nominated as "symbols" — figures, records, mechanics, refreshments, planning, and writing. Still another thought which needs to be expressed is that we are all too prone to think of the volunteer as a woman, and usually an older woman, while there is a vast untouched territory of volunteer service, *especially for older people, for the young person, and for the* man who may have the time and the inclination to join the ranks of people who can be useful in this way.

CONTENT OF TRAINING

What should be the content of training? This will vary in accordance with the field of activity, but there is a certain amount of basic material without which no volunteer should undertake service. I happen to believe that this is true for the person in the home, with members of his or her own family, just as it is for those working in the community. First should be the orientation to the general problems which the aging population is creating for everyone — and the ways in which it is making changes in community and personal living. This does not need to be scientifically interpreted in demographic terms, but can be described in homely examples of what is happening right in the immediate family and neighborhood. This is vitally important in our culture, which has not yet discarded the ideal of the rugged individualist — the independent and self-supporting member of society. We need to give him facts which can help him to

professional worker and the volunteer. Clarification of principles and of roles will gradually emerge.

The question of the availability of personnel again determines whether training should be of the specialist in the professional personnel, who can be a supervisor of the more generally trained volunteers, or whether the aim should be to try to develop volunteers who are specialists. In any mass movement such as this may well be, since the demand for workers is so great, it would seem to be the better part of wisdom to try to create the professional specialist who can consult with and guide the worker, who can acquire his specialization through actual work on the job, through in-service training, and through demonstration projects. It also requires education of all personnel in any program to the understanding that every part of it is vital to its success, even the most routine, and that the routine duties which supplement the work of the trained person are essential to the better distribution of time and skill of everyone in the interests of the older people. Skill in the sharing of these duties with those whom we would serve is often the acid test of both the professional and the volunteer worker.

An integral part of this question which cannot be categorically answered for any single community without careful examination of its resources relates directly to the amount of support which can be given the volunteer in the plan which depends upon the specialist for technical and professional guidance. No worker, trained or volunteer, can be counted upon to continue to perform at a high level if there be no person or persons with whom he can check for judgment as to the quality of performance and upon whom he can depend for a continuing supply of up-to-date information and knowledge to supplement him in his own isolation. To receive consultation and guidance from the

sickness, nutrition, recreation, education (no longer the priority of the very young), church relationships, and community and individual responsibility. There is a rapidly growing body of experience and of literature which can be used to give to any volunteer a bird's eye view of what has been brought together.

Fourth, there are obviously the specifics which belong to any single professional aspect of the program in which the volunteer may wish to function. Whether that be in case work, medical social service, recreational and group work, in library or church work, there are adaptations of the fundamental principles of working with people which obtain. It is in this area particularly that both the professional workers and the volunteers will find themselves groping together — what might be called a case of the blind leading the blind. Each professional group has its own concepts and principles upon which its work is based, but there have as yet been very few attempts to analyze whether the methods now in use for applying those principles are wholly suitable for work with older people. Generic case work we know is sound, but do case workers know how to work with older people and does the process of application of the principles of case work need to be modified in that work? Group workers are beginning to understand group dynamics, but have as yet not enough experience with old people in groups to know whether the methodology in use with other age groups is suitable. Educational or instructional methods in use with younger students would appear to be obviously and advisedly subject to modification for older people in the formal or informal setting of adult education. Therefore, the process of training of volunteers for any one of the larger number of activities in which older people hopefully will engage should be an education for both the

cussion and on which I have only untested ideas to put before you. I have worked with volunteers, I have participated in group training for them, I have trained individual volunteers, and I have served as a volunteer without training for that role. Out of these diverse approaches I have found myself with *some* notions, *a little* experience, and *no* knowledge! But this meeting as I understand it is for discussion and not to supply definitive answers. On this hypothesis only can the following be presented. Also the discussion is predicated on the premise that training is desirable and useful for volunteers as well as for professional workers.

The preliminary part of the training is probably most satisfactorily developed as a series of orientation lectures which have as subjects the various kinds of material which have been suggested, with the generalized sociological topics presented first as a backdrop for the more personalized topics to follow. The answer to the question as to whether these should be given in a rapid series or spaced over a longer time, concurrently with placement in actual work, depends largely upon the specific circumstances. There is a great deal to be said for some types of volunteer work having the lectures immediately followed by exploratory experience either in actual work or in observation of demonstration projects.

In most work we learn by doing, and work with older people is a very good case in point. Being exposed to the actual work, with others or on one's own, gives a worker the very best chance to observe, act, and test out the ability he has to use constructively what he is learning. Many times it has been possible for individuals just stepping into group activity with older people to participate in the social lounge of one of our centers and for them to say that nothing un-

supervisor in order to continue to grow on the job is a basic essential for the volunteer; and training should prepare him for this kind of relationship with the professional staff.

The last major essential in the content of training is that there be genuine education as to resources in the community, and methods for using them. No activity planned for older people ever operates in a vacuum in a community. Almost spontaneously lines go out to other activities, institutions, and services. Complete knowledge of all of these and the way in which they function is not necessary as part of the equipment of the volunteer, but certainly the knowledge as to how to use the information services and the usual resources of the community is a "must." Much futile effort can be avoided for old people and better relationships for everyone are established by a better use of existing resources. This part of the training program can usually be provided by the local community council, if there be one, or if there be no council, by one of the civic agencies, such as the League of Women Voters, which makes it a part of its usual business to educate the public on just such matters. This should include orientation to the legislative provisions affecting both the social and economic situations of older people, as well as their housing and medical care, with descriptions of the agencies whose responsibility it is to administer these services. Nothing should be omitted, as we find the aged everywhere, and their needs are as numerous as those of anyone anywhere — if not *more* numerous.

METHODS OF TRAINING

The final facet of the topic—"how to train volunteers" — is one which probably should have the most expert dis-

things which the board member is puzzled about and the things she actually thinks about what is going on. The group technique is excellent for everyone — for it gradually breaks down the barriers which exist between the professional staff and the volunteer or lay group. I shall never forget my complete amazement after one such session when one very well-poised board member said, "And now I never need be scared of you social workers any more!" All I could think of was a favorite line of MacLeish's about crowds: "Each as frightened of the other." If these sessions could be regarded for what they are — training for everyone in the group and a means of promoting common understanding of a common job in which each is as essential as the other — the board member — the volunteer — and the staff worker, one might really claim that a new day had dawned in community work with older people.

The institute or the workshop, either separately organized or used as inservice training, is by far the most useful device for training volunteers which it has been my privilege to observe. The groups are kept small enough to encourage interchange of opinion and experience. The material presented for discussion is usually carefully planned and is designed for discussion purposes, not for informational instruction. With good leadership the strengths and weaknesses of the program itself, of the volunteers and of the staff, their fears and their hopes are brought out into the open. In one such workshop in which friendly visiting was the focus of work for the volunteers, it was not long before it was apparent that the assured group of women in a substantial suburban community near New York were filled with shyness, with apprehension, with as much hesitation about visiting old folks who were homebound as is a boy who is going on his first date with the girl of his fond-

usual or significant occurred during the time they were there. Those same workers, a few weeks later, after receiving more interpretation of theory and method, have found themselves surprised by the significance of simple acts and events which earlier would have taken place unobserved and if observed would not have been understood. Placement and lectures may then be carried on in an alternating series with profit to everyone.

Demonstration projects are an effective device and can be used for work with older people as well as for work with other age groups. They will be even more useful in the future when experience has been more complete and been more carefully explored to determine what and why there was success or failure in this or that project. Older people themselves are often the ones who open the eyes of workers to the flaws in a plan of work by their own discussion or by the activities they work out without too close direction from others. These are the most revealing when they take the form of skits or songs or poems, or dialogues written about what is going on. Encouraging self-government and self-conduct of programs by groups will bring out the extent of security in the group, of their dependency on leadership, and their approval or disapproval of that leadership by the tendency to imitate or to repudiate methods in use. And observation of members of the group with each other will be more salutary than one is inclined to believe.

For board members and lay people who are coming along so speedily in their wish to keep up with the times and all that they are teaching us, the educational forums and so-called "buzz" sessions are proving to be of great value in bringing to the volunteer the professional point of view in a way which is understandable to her. They are even more valuable in bringing to the professional worker the

things which the board member is puzzled about and the things she actually thinks about what is going on. The group technique is excellent for everyone — for it gradually breaks down the barriers which exist between the professional staff and the volunteer or lay group. I shall never forget my complete amazement after one such session when one very well-poised board member said, "And now I never need be scared of you social workers any more!" All I could think of was a favorite line of MacLeish's about crowds: "Each as frightened of the other." If these sessions could be regarded for what they are — training for everyone in the group and a means of promoting common understanding of a common job in which each is as essential as the other — the board member — the volunteer — and the staff worker, one might really claim that a new day had dawned in community work with older people.

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est hopes. They were worried about what to say — and wouldn't the old people be difficult and cross with strangers? Didn't they like young people better than older people? After these fears were aired and exposed to the light of discussion it was agreed that they would be discussed again at a later date, after there had been an opportunity for a sufficient number of visits to discover just what did happen. When that time came, most of them felt that they had been apprehensive without very much reason, and reported warm welcomes and very rewarding visits. One of them finally put her finger on part of the truth when she said that probably if they had not had the preliminary discussion many of them might have conducted themselves in such a manner as to have created suspicion in the minds of their old folks, but that perhaps by clearing the atmosphere among themselves they had cleared away some of their own stiffness and awkwardness of manner. They continued in each of the sessions, held intermittently during the season of visiting, to give and take from each other and therefore to carry more and more to those upon whom they were calling.

The workshop also provides that sense of sharing with others which each of us needs — that subsidy of association without which one's work can become more or less sterile and stale. Their frequency and size will depend much upon the skill of the leaders, the opportunities for testing out in practice the theories discussed, and upon the type of supervision volunteers may have in their placements. In the more highly developed situations the workshops may prove to be more helpful to the supervisors and co-workers of the volunteers than to the volunteers themselves. Not all professional staffs, and certainly not every place in which volunteers would like to work, can use them well, not even for those tasks which seem simple and direct but which

without training may be either helpful or harmful in the individual's situation, depending on the manner in which it may be related to the plan for him.

Much of this sounds labored – as though volunteer service is something extremely complicated and difficult to administer. It is really neither, but if it is to be fruitful for both the volunteer and the older people it must be carefully thought through and not be the kind of haphazard casual help which many people think it can be, just because it is for and with old people. In my years of experience it has been my observation that much work with older people in the community can be done by volunteers and untrained staff. But it has been my further observation that the quality of that work and the value of it to the older person is enhanced by just so great a degree as is the ratio of professional administration, supervision, or participation in it. It is not exaggeration to state that professional understanding has helped to raise the standards of institutional care; trained teachers have improved the quality of the work of the volunteer services of the American Red Cross to a point at which everyone is proud of the achievement; recreational groups take on a deeper meaning for the individuals and the community when there is professional leadership as an element in the program.

Our community councils are developing committees for volunteer services; the American Red Cross, the American Women's Voluntary Services, the National Council of Jewish Women, which will soon outshine the professional group in its organization of activities for the elderly, the Junior League, which has social services as one of its objectives and which takes this aspect of its work seriously, the men's and women's service clubs, the philanthropic federations as well as the various groups of churchwomen the country over,

and the rural groups, certainly second to none, are all revising their programs to include work with older people and to make an opportunity for many of the oldsters to take part in what is being planned. All of them are seeking ways and means of providing training, and we must not overlook the *facts here of providing that as painlessly as possible.* The adult educators to whom we turn with eagerness for guidance as to how to impart the little that we know and how to learn more from the daily happenings in a world in which more and more old people live cannot fail us now. Too much hangs on their knowledge and their promptness in passing that on to us who would work together for a common cause — a community in which older and younger citizens and professional and volunteer workers join hands to make it a place in which older people share with others the good and the bad, the rights and the responsibilities, *because there is understanding that their needs and those* of the community are, in the long run, the same.

GROUP DEVELOPMENT AND THE EDUCATION OF OLDER PEOPLE

BY ROGER W. HEYNS

Roger W. Heyns, Ph.D., is assistant professor of psychology at the University of Michigan and research associate in Navy Conference Research. During World War II, as research psychologist in the Army Air Forces, he was responsible for the construction and validation of psychological instruments used in selection of officer candidates and of lead crew personnel for B-29 commands. He was later assistant chief of the Psychological Branch of the Continental Air Forces, Bolling Field, D. C.

For the past ten years social scientists have been systematically studying the dynamics and growth of a wide variety of groups. Workers in factories, community leaders, professional groups, and long-suffering college sophomores have been subjected to the experimental scrutiny of social psychologists and sociologists.

The observation and measurement arsenal of these researchers ranges from hour-long interviews with participants to a battery of buttons which group members are required to push when they feel "thin, unhappy or alone." From these many studies, there is beginning to emerge a body of fact and theory which is applicable to the problems of the older members of our society.

I shall discuss a number of dimensions or characteristics of groups, citing evidence for the importance of these dimensions, and attempting to show their relevance to some critical problems in the adjustment of older people. Some

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Cohesiveness. It is a common observation that groups differ in the extent to which members will conform to the rules of the group, in the sacrifices they will make for it, and the regularity with which they will attend the meetings. There are several studies which indicate that these and other behaviors of group members are related to how cohesive the group is. By cohesiveness of a group we mean the attractiveness of the group to its members.[1]

What are the factors which make a group attractive to its members? It is very helpful sometimes to think about all groups as existing to meet the needs of members. They either satisfy these needs directly or are means to their satisfaction. When they stop doing that, the groups begin to die. Some groups have problem-solving functions; a board of directors, for example, is set up to establish policy and make decisions concerning the operation of a company, in order that the total task of the organization can be accomplished Study groups are organized to meet the needs of members to acquire more information about the world they live in. Other groups satisfy emotional needs of members. Some groups, for example, exist because of the social approval and prestige which accrue to their members. There are groups to meet many kinds of needs, and most groups satisfy more than one need for their members. To the extent that a group meets the needs of its members, it is attractive to the members; to that extent, the group is cohesive. To put it another way, there are strong forces keeping the members in the group.

As mentioned above, some of the characteristics of co-

[1] There is a more rigorous definition, and the reader interested in exploring this area more intensively is referred to the reports of the staff of the Research Center for Group Dynamics noted in the References (2, 5, 12) The Research Center has done several experiments on cohesiveness of groups and has the most clearly stated theory concerning its effects

of the factual data to be reported provide support for the theoretical framework which is being developed by professional workers with this age group. Some of the concepts are useful additions to this body of theory.

The term "education" in the title of my discussion is not restricted to more or less formal academic training of older people. I have chosen to use the term to mean the organization of a program for older citizens which will help them to deal with their problems effectively.

What I propose to do, then, is to discuss some theory and some facts about groups which will help us understand more fully the dynamics of older people. The research findings and the concepts will also enable us to utilize groups more effectively in programs for older people. This particular area of application, the effective use of groups, seems to me particularly important because I believe that some of the most pressing needs of our older citizens can be met by groups and that the organization of groups should be an important part of any program for them.

This does not mean, however, that programs for assisting the older citizens are to be completely determined by findings from the study of small groups or from theorizing about them. I am suggesting, rather, that such programs would not be complete without the addition of these insights to those obtained from research in other aspects.

CHARACTERISTICS OF GROUPS

Groups, like people, have many different characteristics. They differ in size, efficiency, friendliness, and so on. Some are highly organized; others are loosely knit and informal in their mode of operation. Current research in social psychology has indicated that one of the most important characteristics of a group is its cohesiveness.

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hesive groups are those which workers with groups find very desirable. Cohesive groups have strong group standards. That is, the members conform to the group's demands upon them (1, 3, 5). Cohesive groups respond more effectively to frustration (6) than do less cohesive groups. There is much more ready interchange of opinion among members (1, 2). The amount of influence of one member by another increases with increase in the cohesiveness of the group (1).

It seems to me that the theory here and the supporting evidence have implications for the use of groups in work with older people. At the risk of elaborating the obvious, let me mention a few. First of all, it seems to me that every *worker must make a "need analysis" of the persons with* whom he is concerned. He must attempt to learn what their needs are, what their fears are. This means rejecting the naïve assumption that all of our older people have the same needs and that any single group will meet all of them. It does not follow from this that the resulting program should contain an infinite number of groups to correspond to the infinite number of unique needs the survey would reveal. It does mean that our groups, when we set them up, will be relevant to the more important needs of the members. Such an analysis will help the workers to select activities for the group which will satisfy the members.

This is only the first step, however. It may be that we are fairly certain that there is a need for a given kind of group. It seems clear, however, that this is not enough to ensure a successful group. The group must be perceived by the members *as meeting those needs or be perceived* as potentially capable of doing so.

This is a difficult problem in more ways than one In the beginning stages, groups are not typically very efficient in meeting members' needs and so the persons who feel that

their group is not efficient may very well be right. Then too, people are not always aware of what their needs are. It is difficult to make people see a group as one which can directly satisfy or provide the means for the satisfaction of needs of which they themselves are unaware.

Some members of the staff of the Psychology and Sociology departments at the University of Michigan had an experience recently which illustrates this point. In a program of counseling freshmen, groups were formed to help the new student meet some of the human relations and adjustment problems that typically arise in the first year of college. Attendance was voluntary. Some of the most proficient group leaders on campus were in charge of the groups. In almost all of the groups, attendance dropped off rapidly until, by the end of the third week, groups which originally had fifteen members were meeting with a membership of two or three.

The observations of the leaders and some research indicated that there were four factors involved in this spectacular failure· (1) some of the original volunteers did not have the kinds of needs that the groups were set up to meet. They were well-adjusted young people, academically and socially, and were taking college in their stride; (2) volunteers who did have the problems which the groups were set up to help them with did not perceive the groups as being capable of helping. The groups did not remain large enough nor long enough for anything to occur which would change the perception; and (3) some students dropped out because there were other more pressing demands upon them, and finally, (4) other groups become more attractive to them We might well inquire in the case of failure of groups for older people to "catch on" and function effectively, whether these same factors are operating.

It is fortunate, however, that cohesiveness can be generated, and generated in many ways. In other words, the enterprise is not necessarily doomed by decisions one makes in the selection of the group activity.

It is evident from experimentation that has been done by Shelley in the Conference Research Project[2] at the University of Michigan that a very positive attitude toward the group as a means to member goals can be quickly established by success experiences (12). This research indicates that one can increase the cohesiveness of groups of older people by taking steps to ensure highly visible success early in the group life. This requires, among other things, well-trained group leaders. I think we are being inordinately naïve, if not perverse, to expect competent leadership to emerge from the membership early enough to ensure group success.

By ensuring success, I do not mean necessarily that the principal group objective need be attained completely and quickly. It is not necessary, for example, that the members of a study group become thoroughly informed on the subject matter in the first two meetings. Here, the fact that groups meet many needs comes to our aid. We must ensure that the group be successful in meeting some of these needs, ideally, the important ones. One general result of a study of seventy-two problem-solving, decision-making groups in business and industry, now being completed by the Conference Research Project is relevant in this connection. We are discovering that the emotional, interpersonal factors are the most important in determining the satisfaction of members with the meeting and the decisions. These results are

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startling when one considers that the groups studied were composed of operating officials of organizations and were working on administrative and technical problems.

This suggests that it is important for a group leader to make the first few meetings of his group emotionally satisfying He can do this in many ways, such as by responding in a positive and approving fashion to individual contributions, by helping the members to find common points of view, and by helping the members to discover that they share similar fears and aspirations. If the early meetings are emotionally rewarding, the leader has made great strides toward keeping his group in existence long enough to accomplish some longer-range objectives he may have in mind.

GROUP BELONGINGNESS

The second characteristic of groups which is relevant to our topic is an emotional dimension of group process. The concept is that of "group belongingness." Not all research workers in the area of small group interaction use precisely this term, but most of them employ concepts having much the same meaning. The general notion here is that people differ in the extent to which they feel they belong to a given group.

We have all had the feeling of not really belonging to groups in which we have found ourselves; we may not share the objectives of the group; we may have fundamental disagreements with the other members in the area of values. We may feel, and this is very important, that the other members do not really accept us. All of these factors, among others, contribute to a feeling of not belonging.

Now, for most of us, this merely means changing our group membership to some other group with whose mem-

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are also increasing their satisfaction with the group product and the attractiveness of the group for the members. The action implications for the person who wants to use groups to help older people may be found in the phrase in the preceding sentence "creating an atmosphere."

We are beginning to gain a better understanding of the ways in which we can create a feeling of belongingness in group members. The leader himself can do a great deal by creating a style of interaction in which he communicates his own interest, respect, and emotional support to the members. The leader cannot do the whole job, however, and there is reason to think that even if he could he should not – in terms of long-run benefits.

One technique for creating this atmosphere of belonging warrants special attention because it is applicable to more problems in group functioning than this one. It is the general technique of turning the problem over to the group for it to deal with. We are finding out, for example, that it is possible for a group to set up, quite explicitly, standards concerning the way in which members should interact. Thus, it was possible for a graduate seminar in psychology to come to the decision that the members will attempt from now on to act creatively, rather than destructively, with respect to the ideas of members. This decision was made in an academic atmosphere in which the prevailing method of achieving status was to demolish quickly and totally the fragile ideas of colleagues. It took some time to get the new attitudes actualized in behavior, but it did take place.

This procedure of setting up group standards regarding behavior is effective because we have found that groups can be helped to look at their own process of interaction; that is, members can be made sensitive to the way their group operates. In the process of looking at themselves, they be-

bers we share values and objectives, and by whom we feel accepted. All of us, however, if we are the least bit sensitive, realize the personal unhappiness which would result if there were no groups to which we felt we belonged.

This concept of belongingness is, of course, not unique to social psychologists studying small groups. Professional workers with our older people have pointed out that an understanding of them involves a realization that they are marginal people. They are in a social-psychological position of great uncertainty. At one time in their lives, most of our older citizens felt strong feelings of belonging to work, to community, and to family groups. Such a feeling of belonging was an important part of their security and feeling of self-esteem. In the process of aging they face a loss in this feeling of belonging.

Lewin has mentioned the importance of belongingness in the adjustment of minority group members. He pointed out that the minority citizens are frequently characterized by uncertainty concerning their group membership, by a feeling of not belonging (10).

These are, of course, formulations which help one to understand the adjustment of individuals in large social contexts. It is now becoming apparent, from research studies, that the individual feeling of belonging has important effects on the functioning of groups. For example, in the study of seventy-two industrial and government groups mentioned earlier, the groups most satisfied with their decisions and with their meetings were those whose members accepted each other as participants and provided support for each other. In other words, by creating an atmosphere in which members are accepted and emotionally supported, we are not only increasing the adequacy with which group members adjust outside the group, we

can go further in increasing the cohesiveness of groups. This brings me to the concept of functional roles

FUNCTIONAL ROLES

If one does only a minimum amount of thinking about it, one becomes aware that in almost every kind of group there is some specialization of function, some division of the group task in order to accomplish the objectives of the group. This does not mean that each member has a unique function or role; it merely means that there has been some allocation of specialized duties. For example, in a discussion group there may be people performing the role of the leader, the social "oiler," the expert, the clown, the disrupter. The chairman, the treasurer, and the secretary are more common terms which we apply to group members with specialized functions.

These duties differ in importance and in the value which the group assigns to them. Some groups are more skilled than others in preventing overlapping functions Some are more successful than others in ensuring that all necessary functions are being performed. The extent to which these specialized functions are performed adequately affects markedly the productiveness of the group. The extent to which the members perform useful functions for the group determines the extent to which they are needed by the group, and perhaps, more important for our purposes here, feel needed There are several studies in the literature which indicate that groups in which the members need each other, that is, are interdependent and have high regard for each other, are more satisfied with the group product than groups not so characterized (4,8). There is also evidence that those persons who feel that they have prestige in the eyes of their fellow members, whether they

gin to deal wth the reasons for their current method of behavior. This process of self-diagnosis may start at a very superficial level. It gradually progresses, however, to such fundamental problems as personal dislikes and hostilities, struggles for status and disagreements as to objectives. When this process is part of an attempt to improve the efficiency of the group, rather than an attempt to deal punitively with individual members, the net result is increased efficiency and greater acceptance of each other among the group members.

One of the ways, then, in which a greater feeling of belonging can be achieved is by making this an explicit problem *for the group.* On the basis of work with groups in which there were middle-aged and older people, I have no reason to think that this task of helping a group to become sensitive to its problems and to solve them is any more difficult with older than with younger people.

I have been discussing the use of this technique for creating the feeling of belonging in groups composed entirely of older people. The same technique can be used, even more effectively perhaps, with groups whose memberships contain younger as well as older people. In these groups, the older people are usually marginal members and eventually leave. These groups can also directly attack the problem that some of their members — the older ones — lack a feeling of belonging. I am of the opinion that this often happens when the group as a whole is unaware that such a thing is taking place and has no desire to foster it.

Up to this point I have said that when members feel they belong to a group and are accepted by the others, the group becomes more attractive to them. This increased attractiveness is important for members' happiness and efficient group functioning. There is reason to believe, however, that we

this sequence at least, there are physical and physiological changes resulting in real or fancied loss of skill. These tend to make the older person himself doubt his ability to perform useful functions

To sum this up, in contrast to having the feeling that he is playing an important role, and being regarded by those about him as doing so, both of which are important for group productivity and member happiness, the older citizen is faced with loss of such a role. He has only roles of low prestige available to him and lives in an atmosphere which deprecates inactivity and his ability to perform useful roles. And, finally, he has a body which leads him to think society is right.

In the light of this it seems to me that to provide groups in which our older citizens can perform functions of importance to someone is in itself a highly desirable objective. We shall be doing something to reduce the feeling of not being needed, of being "on the shelf," which older people frequently report.

The specific implications of these findings for the manner in which groups of older people should be helped to organize themselves may now be considered. It is important that the group tasks provide opportunity for the development of interdependence among the members. Practically, this would mean that an activity which permitted a breakdown of functions, a division of tasks among all the members, would be preferable to one which could be carried on by one or two members and vastly more desirable than one which depended on an outsider.

We have found that the people who are regarded as most valuable are the high participators (7, 11). Ensuring a great deal of participation in the group activities will help to produce "needed" people. This same sort of thinking

have or not, are more satisfied with their group and its product than those who feel they lack prestige (9).

There are a host of implications in these findings. I shall attempt to elaborate on only a few of them. First of all, there are implications for understanding the social situation of our older citizen. We have this evidence of the importance of functional roles for individual happiness and satisfaction. On the other hand we have the fact that the older person has already lost, or faces imminent loss of a functional, meaningful role, and hence the feeling of being needed, in a wide variety of social groups – in his work group, in the family, and in the community. Add to this the fact that there is a general cultural devaluation of inactivity. The position of one who sits and watches is not conducive to prestige. Then, if we think about the ways in which he can get acceptance and the feeling of being useful, we find that the functions which are most readily available to older citizens are usually of a sort which have little esteem or social value attached to them. The grandmother attempts to perform functions of value to the family group by darning the socks or doing the housework, activities valued primarily by the harassed daughter or daughter-in-law. The grandfather becomes vice-president in charge of the lawn, functions which ten years earlier he would have assigned to the youngsters in the home. These are illustrations from the family group; the same point could be made concerning functions in the work group and in the community. Functional roles are either not available or have little prestige value.

To complicate the situation still further, we all recognize the existence of a general depreciation of the ability of our older citizen to perform functional roles of importance to the group. Then, finally, as a kind of crowning blow, in

munity problems and resources by citizens themselves, under the guidance of experts, has been well worked out. These surveys have concerned themselves with many different kinds of problems: juvenile delinquency, health conditions, racial discrimination. The self-survey technique is especially useful in educating the citizens as to the scope of the problem, the resources the community has available to meet it, and the practical requirements which any solution will have to take into account.[3]

Would it not be possible to organize groups of older citizens to make surveys of various problems in the community? The general objective of these separate studies would be to determine the extent to which the needs of the community are being met. The survey itself would be useful, and, as a result, the participants themselves would have the feeling of doing something of importance and value.

This would be just the first step, however. On the basis of such a survey, an action program could be planned. The older citizens making the survey could then select from needs not now being met by the community and choose certain ones to be their special province. This would involve, of course, dealing with other groups in the community to ensure acceptance of their new function. It is not unrealistic to predict that such a program would terminate in a functional role in the community for the older citizen. And this, a valued, esteemed, useful role in small groups, and in the community as a whole, is an objective which we all feel must be attained. It must be attained not only that later years can be happier, but also that with such a solution,

[3] The *Journal of Social Issues*, No 2, 1949, is devoted entirely to community self-surveys as an approach to social change. The style of presentation and the content of the issue make it very useful to the practitioner.

applies also, of course, to groups of younger people from which older members are gradually ejected or voluntarily, but reluctantly, leave because they no longer serve a function which they, nor any one else, perceive as important and valuable. It is easy to defend the proposition that our elder *citizens can perform useful functions in many groups* from which they now silently steal away. It should not be too difficult to institute certain roles for the older members in these groups or to reorganize the way in which some of these groups operate to ensure important and useful roles for older members. One large company has assigned to its senior employees the task of participating in the community committees. These men have been given the job of *discharging the company's responsibilities to the community.* It seems to me that political organizations might well think about enlisting the services of older people for such tasks as preparing campaign literature, getting out the voters, and soliciting funds. Instead, they make futile attempts to enlist the active co-operation of younger people who are much too preoccupied with their day-to-day tasks to be really effective.

There is *another implication for groups of older people.* While groups formed to "keep them busy" are of undoubted value in the adjustment of older people, it is important to go further than that. If we make a concerted attempt to have the groups themselves serve some important purpose for the community, we shall add to the value of these groups for the members. I have a concrete suggestion to make in this connection. It contains many of the ingredients which I have been contending are necessary for successful use of groups in work with older people.

An increasingly popular and valuable community activity is the self-survey. This technique of surveys of com-

munity problems and resources by citizens themselves, under the guidance of experts, has been well worked out. These surveys have concerned themselves with many different kinds of problems: juvenile delinquency, health conditions, racial discrimination. The self-survey technique is especially useful in educating the citizens as to the scope of the problem, the resources the community has available to meet it, and the practical requirements which any solution will have to take into account.[3]

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we will not be losing some of our most important natural resources — the wisdom and experience of our elder citizens.

To summarize, the use of groups can be an important and useful part of any program to assist the elder person. Membership in groups can directly satisfy some of the needs of these people, and can be the means to the satisfaction of others. To use groups effectively, well-trained leaders are necessary in order that these groups will be as cohesive as possible. These leaders will do well to attempt to increase the feeling of belongingness in the members of their groups and to organize them so that members perform useful functions in the group activity. Finally, the total program will be most effective if the groups themselves perform some useful and valued function for the community.

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A MID-CENTURY FORECAST FOR THE AGING

BY WILMA DONAHUE

Wilma Donahue, Ph.D., is lecturer in psychology and research psychologist in the Institute for Human Adjustment at the University of Michigan. She has been responsible for the development of research in gerontology and of classes on "Living in the Later Years" co-sponsored by the University of Michigan Institute for Human Adjustment and the Extension Service. Dr. Donahue was chairman of the Section on Education for an Aging Population of the National Conference on Aging held in Washington, D.C., in August, 1950. She is a member of the Committee for an Aging Population of the National Education Association and a member of the Governor's State Commission on Aging in Michigan. She is co-editor of Planning the Older Years, *contributor to the book* Living Through the Older Years, *and author of many articles and papers on aging.*

A year ago an attempt to predict the course of future developments with regard to the aging would have been an eminently hazardous undertaking. We were, indeed, conscious of the emergence of an expanding interest in the field of gerontology, but the channels of activity in which that interest would be expressed were not conclusively apparent. In this latter respect, the year 1950 has been an auspicious one for the cause of the aging. In this year we have witnessed a consolidation of position. As Clark Tibbitts has pointed out in the opening chapter of this volume, we have come to view the results of the shifts in population structure as representing elements of fundamental national concern. Prepared on the eve of the first National Confer-

ence on Aging, his remarks brought into sharp focus the nation-wide scope and the deep-seated character of the social, economic, health, and emotional problems of the aging population.

This final chapter is being written in the afterglow of that notable national forum. In that assembly, and in the meetings of the First International Gerontological Congress which were held in Belgium earlier in the summer, the contributions of the country's foremost leaders in the field of aging have promoted the adoption of a more understanding, purposeful, and co-ordinated approach to the solution of the problems of the aging. Out of the interplay of the ideas expressed, concepts are emerging which will direct the course of programs for the social, economic, and personal adjustment of the aging during the present period of transition and throughout the next half century. By no means have final answers been evolved, nor can they be worked out until many new researches have added their bits of knowledge to the whole and have revealed hitherto unrecognized basic problems for exploration. Moreover, the solutions adequate for the problems of today's old may soon become obsolete because the powerful dynamic phenomena of shifting population structure, of changing attitudes toward the aging and aged, and of new social inventions are already at work to change the needs and problems of the old of tomorrow. Implicit in the outcomes of the year's activities, however, are certain directives for action, and it is on the basis of these that it is possible to forecast broadly the nature and outcomes of future planning and programs for the aging.

HEALTH PROGRAMS

The present expansion of interests and knowledge in the

area of geriatrics, the impetus which is now being provided toward a redesigning of health programs in an effort to meet the needs of the aging, and the current preoccupation with the applications which can be made from medical discoveries to improve or safeguard physical health at all age levels suggest that the chroniclers of medical progress of the next half century will record an unprecedented maintenance of health among the older segment of the population. This extension in the individual's period of physical vigor, as well as in his longevity, will stem from a variety of factors. In the first place, future generations of older people will have grown old in an era which has popularized the principles of preventive hygiene. Thoroughgoing health education programs which emphasize early attention to symptoms of disease, and which are implemented by effective mass detection devices, will be fundamental elements in a widespread adoption of preventive practices. Present planning with reference to meeting the health needs of the aging also gives promise of the appearance of the local geriatric clinic as a familiar institution. Organized to serve older people by providing health counseling and by utilizing techniques of medical treatment based upon accumulating knowledge regarding the retardation and control of chronic illness, this type of center will materially reduce the gap that now exists between the level which medical information has reached with respect to the degenerative diseases and the level at which that knowledge is applied.

An increasing volume of basic research investigations exploring the unknowns of degenerative disorders and the development of new therapeutic techniques will combine to produce an acceleration in progress in preventing the onset of chronic disease as well as in its treatment. The

implications of refinements in hormonal and drug therapy also bear significantly upon a prediction of the maintenance of physical health and the retardation of aging characteristics in the older individual during the coming decades. Physicians will find that they command potent means not only for curing a wide variety of infectious and chronic diseases but also for reducing very substantially the period of disability which those diseases impose.

Another factor which may be expected to contribute to the preservation of a higher general standard of health among the aging individuals is the development of a broadening consciousness of what constiutes proper dietary habits. This will be accomplished not only through further progress in determining the role of nutrition as a deterrent to physical involutional processes and malfunction in the aging organism, but also through intensive programs of health education resulting in a widespread adoption of dietary habits which put into practice the expanding body of nutritional knowledge.

The importance of the concept of providing preventive and restorative rehabilitation services for the older patient has also come into recognition in current planning of medical programs for an aging population. Indeed, rehabilitation schemes form a logical adjunct to the institution of broad-scale programs of preventive medicine and the continuation of efforts to develop improved methods for curing or controlling the disablements that accrue with age. A more optimistic attitude toward the rehabilitation of older people is justified because it has already been demonstrated that the older patient, in whom the progress of disabling disease has been arrested, can often be restored through rehabilitation practices to gainful employment. During the ensuing half century the application of these practices may result in a decrease in the proportion of older

people who are dependent upon public and private funds, in an increase in the number of individuals available to the labor force, and, more subjectively, in an amplification of the scope of psychological satisfactions available to those individuals who are served. Similarly, a broader interpretation of the function of rehabilitative medicine is emerging and will go forward. In cases in which the extent of disablement precludes restoration for gainful employment, rehabilitation will focus upon enabling the patient to care for himself and to perform everyday domestic tasks. This, in turn, will conserve professional personnel and release facilities for use in more acute situations.

Finally, it is reasonable to expect that the developing health service features of social legislation and the improvement and expansion of group health programs will assume an important role in contributing to the achievement of a new level of general health security among future generations of the aging.

ECONOMIC PLANNING

The financial plight of the present generation of older people has ushered into disconcerting perspective the need for extensive social and economic changes which will provide assurance of income throughout the individual's lifetime. Older people derive their incomes from personal savings, contributions of relatives in cash or in kind, employment, work-connected private pensions, charity, and from the federal programs of annuity and survivors' benefits and public assistance. It is now rather clear that, in place of the uncertainty of individual savings and family contributions, chief reliance in the future will be placed on public and private annuity or pension systems based on employer-employee contributions accumulated during the

financially productive adult years. It is likely, too, that the old age assistance grant, with its dependence on the needs tests, will eventually give way to the more dignified annuity programs. At the same time, increased support may be expected through medical and other forms of direct services provided out of general tax funds.

Private pension plans, which have mushroomed in recent years, have imposed obstacles to worker mobility that are now assuming glaring importance. If these plans are to be continued, some type of vesting system will need to be established to prevent the worker from becoming frozen to one job and to protect him against possible failure of the employing agent. These limitations and other uncertainties inherent in private pension systems, however, may point toward further expansion of a single, national social security program.

One of the most critical problems in the economic sphere is that involved in providing for the continued employment of older workers as long as they are willing and able to produce. Such an action would constitute a reversal of a seventy-five year trend toward smaller participation in the labor force of older persons and would have to be accomplished in the face of steadily rising worker output per hour. At the same time, it is becoming more generally recognized that the interest of the national economy demands an increasing output of goods and services which can be achieved only with the aid of our aging labor force. This conclusion is manifestly true during the present emergency period.

While prediction is hazardous in this area, it does appear that national needs, demands for adequate financial support, and the desires of individual workers for useful activity will operate to eliminate compulsory retirement practices based on arbitrarily chosen ages. These will be

replaced by policies based on functional capacity to produce. In addition to modifying retirement policies, management will also develop an awareness of the need for planned retirement and will share a responsibility with the community to inaugurate programs of preparation for retirement.

The development of industrial practices favorable for the older worker will be dependent, to a considerable extent, upon needs for augmenting the labor force. A period of labor shortage would give rise to experimentation with part-time employment, shifting to jobs with lower physical demands, modification of jobs, retraining programs, and gradual retirement. Severe labor shortage would necessitate a redefinition of the role of older women and might bring many more of these into the worker category.

In summary, an integrated program of liberalized employment policies, disability pensions, extended social security benefits, adjustment of pension benefits to fit individual needs, and a system of incentives toward continuation of employment may well result in a formula which society can use to provide financial security for its aging population.

PSYCHOSOCIAL PLANNING

It would be misleading to contemplate the emergence of a healthier and more economically secure older population apart from a consideration of attendant accommodations in cultural patterns and practices. As individuals become recognized as having continuing need and capacity for retaining at least partial autonomy in their later years, housing and living arrangement plans will be designed to maintain older people in independent roles as members of their families and communities. While a larger number of con-

gregate living units will appear in response to the need for supplementary individual housing, such units will be designed to secure an independent status for their older residents in addition to making health care, social service, and domestic services available on a convenient and relatively inexpensive basis. Current trends also indicate that the practice of building homes for old people in remote areas will soon be outmoded. Homes will be built amid normal community surroundings and proximal to such community services and facilities as churches, shops, libraries, lecture halls, and recreation centers. In addition, nonresident or out-resident plans will extend the facilities and programs of the homes to include the old people of the community and thus assist them in maintaining independent living arrangements for a longer period of time. The wide individual differences which are apparent in the housing needs of older people will lead to a multiplicity of experimentation with various housing patterns. Unfortunately, among the projects which will probably be attempted more than once will be that of a colony or community designed especially for old people which will virtually segregate them from normal community life. While such a community may meet the needs of certain old people, negative aspects embodied in the removal of the individual from his home community, in his forced association with only his peers or other older people, and in severance of personal contact with the vital issues of the outside world will militate against its universal adoption.

Whatever form planned living arrangements and facilities may assume in the future, it is clear that provision for psychological satisfactions will become as basic a requirement for meeting home standards as cleanliness, accident

prevention devices, adequacy of food and health care, fire protection, and so forth.

Another characteristic of future planning to satisfy the psychosocial needs of the aging will be the abandonment of the concept that complete leisure is the keystone to contentment in old age. Excesses of any activity result very quickly in satiation and in negative response. The leisure time of old age must be structured so that continuity in life pattern of work and play is preserved. Recognition of the opportunity to enhance the usefulness of one's social contribution as a reward of aging will most certainly supplant the current "ideal" of retirement to unlimited leisure.

This is not meant to imply that old people will not possess greater amounts of leisure time than when younger, or even that more of their leisure may not be devoted to recreational pursuits. It does appear certain, however, that if community planning crystallizes at a level which provides merely recreational opportunities, the needs of older people will only partly be met. Fortunately, the formation of community committees for the aging with broad representation including older people is already furnishing evidence that programs of the future will take into consideration the breadth and complexity of their needs.

Older people who maintain their economic independence, physical comfort, and a well-defined community role of recognized usefulness will be freed from the frustrations which now foster anxiety and maladjustment. Individually, this new security will reflect itself in a lessening of physical disease and psychosomatic disorders, in the maintenance of ability to adjust to the exigencies of daily living in spite of changing physical resource, and in improved personal relationships. For the family, it will mean free-

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Whatever form planned living arrangements and facilities may assume in the future, it is clear that provision for psychological satisfactions will become as basic a requirement for meeting home standards as cleanliness, accident

personnel to cope with the health, economic, social, and emotional implications of the expanding proportions of older people.

In defining objectives and in establishing educational programs, educators will also assume a responsibility for promoting the widespread adoption of attitudes of acceptance toward older people. Utilizing all of the varieties of mass media, educational campaigns may be expected to exert a far-reaching influence not only in discrediting those stereotypes and misconceptions which are now prejudicial to the aging, but also in replacing these with a positive regard for the worth of the older individual.

RESEARCH TRENDS

The most strategic of current needs is that for basic research upon the progressive changes associated with aging and upon the interrelationships between the aging organism and the social environment. Medical and physical research, although as yet very limited, is already recognized as having outpaced social research with the resultant creation of a dangerous imbalance in knowledge. Immediate research goals in the next few decades will accordingly be aimed at accelerating social research, so that we shall not continue to find ourselves in the embarrassing position of prolonging human life without providing opportunities for prolonged usefulness. The nature of the aging process and the control of chronic disease will continue as areas of major interest, but increasing attention and support will be given to investigations of the sociological, economic, and psychological aspects of aging.

Private and public research funds have already been made available for gerontological studies, but they have been inadequate to meet the needs for long-term investiga-

dom from guilt feelings arising from inability to provide directly for all of the needs of its older members, and from the disillusionment of changed emotional relationships which occur when parents are reduced to a state of family dependency. From this restructuring of social pattern will arise an improved level of mental health among the aging.

Inquiry may be directed appropriately to the question of preparing society to integrate the aging into its functional life, and of preparing the aging individual to expand his personal growth into advanced levels of maturity. This represents the challenge to education. Admittedly, education cannot bring about changes with the speed and inclusive reorganization of nuclear fission, but it is capable of changing a whole social order within the span of a few short years. We need but refer to the rise of Nazism to appreciate the power of education to change a world order within the space of a fragment of a lifetime. It is therefore reasonable to assume that education has an opportunity and a responsibility to produce extensive modifications in the traditional pattern of social programs. Contemporary acceptance of the concept that educational opportunities and services must be provided to the total population makes imminent a reinterpretation of existing provisions and an institution of new educational programs with reference to the needs of older adults. Specific course offerings and informal educational programs will be designed to reach and to provide valuable information needed by older people. Research carried out in educational institutions and elsewhere will be characterized by an increasing number of gerontological investigations, with special emphasis upon the problems of capacity, motivation, and techniques for life-long learning. In addition, a variety of professional training programs will be introduced to meet the need for

personnel to cope with the health, economic, social, and emotional implications of the expanding proportions of older people.

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tions or for integrated research programs. So critical is the need, however, that it seems indisputable that the demands for augmented research funds and for a central agency which can sponsor both public and private research programs, and in addition, assist in the dissemination and application of research findings, will be met in the near future.

CONCLUSION

At mid-century it is evident that the challenge of an aging population has been accepted by the American people. The increasing numbers and proportion of old people in the population have forced the making of a social choice regarding the manner in which they will be treated in our culture. So recently has the decision been made to set aside prejudice against the aging and to insure life-long opportunities for worth-while individual experience that we are still in a transitional period, with the consequence that the millions who are now old are caught in a critical interim during which the tide is changing. Happily, the force of mounting interest is accelerating the tempo of activity at all levels. In this discussion only a few of the basic changes in attitudes and action have been cited which are already casting their shadows before them. Local and state interest in the aging is becoming reflected in legislative programs, in the formation of commissions, and in an expansion of facilities to accommodate the aging. Even more recently, the magnitude of the problem and the need for continuity and integration of action have been recognized at the national level in the Federal Security Agency appointment of a permanent interdepartmental Committee on Aging and Geriatrics, which will function to develop programs and to provide information and guidance for those public

and private agencies seeking to promote the welfare of the aging.

Our mid-century forecast for the aging brings into prospect all of the elements necessary for the construction of a design for living in the later years which will provide opportunity for the realization of the nobler resources of maturity and the expert consummation of the pattern of life.

> . . . age sets its house in order, and finishes its works, which to every artist is a supreme pleasure.
>
> —Ralph Waldo Emerson

INDEX